Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10 2000 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Futurecare Pineview Prince George Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Vear Months Days Hours Min. 1 X M 2 □ F 577-24-5640 88 Yrs. 9,1921 Jan North Carol Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Evantary with the notified at once. Director DC 1 ☐ Yes 2 No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1519 East Capital St. SE 20003 USA death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Payes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify:Black Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banding Machine Operator | Bureau of Engraving 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Perry Thurman Perry ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 East Capital St. SE Wash, DC 20003 Edna Perry (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 26,09 Brentwood, Maryland Lincoln Cem 20011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tyrone J.Young719 Kennedy St.NW WashDC 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death cations that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Five SC (enotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Artilioschatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🕍 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural 5 Pending death. 1 ☐Yes 2 ☐ No e Hospital or Attendi 24 hours after death. e Funeral Director: / investigation 2 Accident completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the within 2.

State Registrar

(Check only

29b. Signature and title of certifier

Medical

MU Loverston Road, Fort WASHINGTON I AWNER MM 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D35 206

29d. Date signed (Month, Day, Year)

Physici /Meaid Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Mailland Experiment must be notified at another.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

Sta

Registrar				CEI	uncate or	Deall	,	1	Reg. No.			
1. Decedent's Nam			r					2. Date of Dea Month	ath Day	Year	3. Tim	e of Death
		ive street and number)			4b. City, Town, o	v Location	of Death	Oct.	10	County of Dea	1 07	08 "
Peninsu	1 11	nu Medici	. () 1	/	40. City, 10Wit, 6	hur)		1	Williami	.0	
5. Social Security N			e (In yrs. last b	irthday)	If Under 1 Year		7 r 24 Hrs.	8. Date of Birt	h (9. Bir	thplace (Sta	ate or Foreign
215-38-2	2215	1□M 2 X]F	68	Yrs.	Months Days	Hours	Min.	(Month, Da 05/25/	1941	Nor	th Car	colina
Usual Residence o											Table to	
10a. State	10b. County		10c. City, To									e City Limits Yes 2 □ No
Maryland	Wicomi	.CO	Sali	sbur	-							
10e. Street and Nu		n Street			10f. Zip Code	304			10g. Citiz	zen of What Co λ	ountry?	
	vasiiiigu	12. Was Decedent	Ever in II C	12 1			rigin? (Cn.	acifu Va a or No		14. Race - Ame	arioon Indio	
11. Marital Status	ied 2□ Married	Armed Forces?		13. 1	Vas Decedent of I Yes, specify Cub	an, Mexica	an, Puerto	Rican, etc.)		Black, Whit		ι,
3 X Widowed		If Yes, Give Year or Dates:		1	□Yes 2X No	Specif	γ:			Specify:	white	
10	15. Decedent's E	Education	16	a. Deced	ent's Usual Occu	pation			16b. Kir	nd of Business	/Industry	
Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	life. E	kind of work done OO NOT use retire	during ma d)	ist of worki	ng				
12		_	, I	seams	stress				clot	hing m	anufac	cturing
17. Father's Name								e (First, Middle,	Maiden S	Surname)		
George V	V. Burche	ette				Ro	xie L	uffman				
19a. Informant's N			19		g Address (Street							
	Parker	S/SON			20 Caraca	ara D						
20a. Method of Dis 1 🔀 Burial 2		Removal from State	Wicom	of Dispos ery, crem	sition (Name of natory or other pla Memorial	ce)		O (OO		cation - City or		9
	5 Other (Spec	i(y)		<u>Park</u>		- 1	10/2			isbury,		
21. Signature of Fu	une/al Service Life	ensee		24	HOTIOWAY 501 Snow	Füffe Hill	ral H Rd.,	lome Pro Salish	ofess oury,	sional MD 21	Associ 804	iation
a. Art t. Enter t	he disease, or con	nplications that ca	the teath. Do	not ente	er the mode of dyi	ng, such a	s cardiac	or respiratory a	rest,		Approxi	mate Between
Immediate Cause	(Final	one cause on sch li	ne.	· M	ORAN						Onset a	and Death
disease or condition resulting in death)	on	a. Due to lo 78	a consequence		10,2411	7					750	
Sequentially list co if any, leading to im cause. Enter Under	nditions, nmediate	Due to (or as	a consequence	of):								
cause. Enter Under that initiated events	S 188	C								51		
resulting in death)	Last	Due to (or as	a consequence	of):								
		d										
IF FEMALE:		00. 11										
23b. Was deceden in the past 12		23c. If yes, outcome 1 Live birth	2 Fetal deal	th 3[Ectopic pregnanc	су			2	3d. Date of de Month	elivery Day	Year
1 □ Yes 2\ 9 □ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown	it time of death	5∟	Other (specify) _						,	
		contributing to death b	ut not resulting	in the un	derlying cause div	en in Part	l.	23e. Did to	obacco u	se contribute to	o the cause	of death?
		REGUR	-			/ wit			es 2			Unknown
				-						1	200	
								24a. Was autop		24b. Were a prior to death?	completion	of cause of
		T						1 □ Yes	2 No	1 ☐ Yes	s 2 No	
25. Was case refer examiner?	,	Hospital:			Oth	ner		(Check only o				
1 ☐ Yes 2 Z	No	28a. Date of Inju		Outpatient Time of	1 3 1 DOX	4 🗆 🗅		me 5 Residence Residence Page 1			ecify)	
Natural	5 ☐ Pending investigation	(Month, Da	y, Year)	Injury	28c. Inju Wor M 1	k? Yes 2[zou. Describe i	iow irijury	occurred		
2 ☐ Accident 3 ☐ Suicide	6 Could not b	oe Osa Blaca of Ini	urv - At home 1	arm stre		1163 2		28f. Location (5	Street and	d Number or B	tural Route I	Number
4 Homicide	determined	building, et	c. (Specify)	arri, ou	ot, idotory, omeo		- 1	City or Tov			urar riodie r	tumber,
29a. Certifier	12 Certifying P	hysician: To the best	of my knowlede	ge, death	occurred at the ti	ime, date a	and place	and due to the	cause(s)	and manner a	as stated.	
(Check only one)	2☐ Medical Exa	miner: On the basis of and manner st	f examination a	and/or inv	estigation, in my	opinion, de	eath occur	red at the time,	date and	place, and du	e to the cau	se(s)
29b. Signature and	title of certifier				29c. Licens	se number			29d. Date	e signed (Mon	th, Day, Yea	ir)
> /	112				D	383	3 5 3	?	10	1151	2000	?
30. Name and addr	ess of person who	completed cause of c	leath (Item 23a) (Type, F	Print)	-		,	20	100/	100	
RENE D	ESMARA	is MD	1008	CA	Print) PRAVIL S	54. 5	SAL	sbung	m	2 21	1801	
31. Date filed (Mon	DCT 20 2	32. Registr	ar's Signature	1	0. 4.1					,		
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Registr

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician MARK POTTER 26, 2009 2:00 A STEVEN Oct. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Abingdon 602 North Branch Court Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 4/16/1 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1**X**M 2□ F 49 Yrs. Maryland 216-74-6489 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Abingdon Harford MD. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 21009 602 North Branch Court Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 λq White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Disabled) None 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Heelth and Mentat I ent: If item 27 is marked of Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21236 19a. Informant's Name/Relationship (Type, Print) 9649 Belair Rd. Ste. 102 Nottingham, MD. Sandra Chilton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State = 5 Department of the post of the Jarrettsville Cem. 10/29/09 Jarrettsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E.G. Kurtz & Son Funeral Ladder Jarrettsville, Maryland Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each link. Immediate Cause (Final WPPK **Physician** disease or condition resulting in death) /Medical Examiner ai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 200 3 Probably 4 Unknown t □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificete hes b firector, page 2 s autopsy 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours efter the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and alone, and due to the naute(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a, Curtflet Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20056091 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elcamp 2101 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 35504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1:30 A M Grace McAdams Rose October 20,2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Bradford_Nursing Home</u> Prince Georges Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1922 N.C. 1 □ M 2 K F 86 November 242-28-9477 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 13212 Chalfont Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 1 □Yes a No Specify: If Yes, Give Year or Dates: Specify: 3 V Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fletcher Thomas Fitch, Sr. Vera Myrle McAdams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Rose / Son 5208 Vaughan Court, Waldorf, Maryland, 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet's Cemetery Oct. 26, 2009 Cheltenham, MD. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) consequence of Evide Dust Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident

Physician /Medical Examiner the death certificate be executed

and

P.O. Box 68760

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental HImportant: If item 27 is marked othany injury or other traumatic event

with the Maryland fshow

death

within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Completed by Be

Certification: To

Medical

attending physician a for use as the burial-1 signed by the director 24 hours after death.

Funeral Director: After thi etely filled in by the funeral

Hospital or Attending Physiclan: The law requires that

Division of Vital Records,

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

3 Suicide

29a. Certifier

4 Homicide

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce lifte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Could not be determined

29c. License number 775206

(1701 CrVingston Rond Interestruction may lay

State Registrar

completely

within 2

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08347 State of Maryland / Department of Health and Mental Hygiene Thomas Lee Robertson Amended ite Registrar #4c, perM.E., 10/30/09

Physician/ 1 Decedent's Name (First, Middle, Last) Certificate of Death BA Reg. No 2. Date of Death Physician/ Month Day October 27, 2009 2325 hrs Medical Examiner <u>Thomas Lee Robertson</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Somerset Wicomico Peninsula Regional Medical Center Salisbury 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months Davs Hours Min Country) Maryland Director 1X M 2 F Nov. 7. 1960 48 212-72-2194 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10h County 1 Yes 2 X No items 23a or 28a-f show ust be notified at once. Worcester Pocomoke City MD death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 2053 Bypass Road 21851 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Armed Forces? Yes 2 X No ٥ Specify: White Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Yes, Give Yea Divorce Widowed 4 If item 27 is marked other than "natural", traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Tree Trimming Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn L. Petitt Be Thomas Ira Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ၉ 2053 Bypass Road, Pocomoke City, MD 21851 Michelle Robertson (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) or other 1 X Burial 2 Cremation 3 Removal from State 11/1/2009 Marion Station, MD Paul's Cemetery Donation 5 Other Specify: 22 Name and Address of Facility HOLLOWAY Funeral Home, Professional Association Signature of Funeral Service Licensee 107 Vine Street, Pocomoke City, MD 21851 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED attending physician for use as the burial 23a,27,perm,E g897 11/19/09 TT Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? After this certificate has performed? 2 No Yes 2 1 1 Yes page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director æ Other 4 examiner? Hospital: Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ၀ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Director: Pendina 24 hours after death. Funeral Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City in by 28e, Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) **OCME** October 28, 2009 O.C.M.E. rde

State 31. Date filed (Month, Day Registrar

30. Name and address of person who completed cause

Theodore M. King, Jr., MD.

ORIGINAL

111 Penn Street, Baltimore, MD 21201

of death (Item 23a)

Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

amend #10 state of War Gand / Department of Health and Mental Hygien 9 009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:45 pm Jacob Wendell Stroheker October 2009 20. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours Illinois 327-18-6745 11/21/1920 88 Director Usual Residence of Decedent 10d. Inside City Limits Department of Health and Mental Hygiene.
Important: If lear 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once. 10b. County 10c. City, Town or Location Prince's Georges 1 ☐ Yes 2 No Director Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 U.S.A. 8213 Tahona Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Cartographer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi th and Mental F 7 is marked ott Be John William Stroheker Lena Wendling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 17 Wolf Drive, Silver Spring, Maryland 20904 John W. Stroheker - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Pk. 10/24/2009 Rockville. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 71800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease condition **Physician** resulting in death) /Medical Due to (or as a con-quence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached o 9 Unknown 0 signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate 1 ☐ Yes 2 ♠ No 2 🗆 No director 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 2 Accident 5 Pending To the Hospital or Attendii within 24 hours after dea h. To the Funeral Director A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 含 4 Homicide .⊑ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Datersigned (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

09-08218 John Scott Shank Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 35507

			1-For State Certificate of Death Registrar	Reg. No.									
adio	Physici al Exam		Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year October 22, 2009 3. Time of Death 2133 hrs									
suic	ai Exaili	IIIC	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	of Death 4c. County of Death									
			Washington County Hospital Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1	Washington der 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign									
	Funeral Director		215-48-3031 1 x M 2 F 55 Yrs. Months Days Hour	Country									
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
	3		Maryland Washington Boonsboro	1 Yes 2 X No									
	the Maryl	Director		U.S.A.									
	death with or items 2.	Filneral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	un, Puerto Rican, etc.) White, etc. white									
	s after iral", niner	2	3 Widowed 4 Divorced in test store test or Dates: 15 December 5 House to Consider the physical part of the property of the pr										
	72 hour n "nate al Exan	peter	during most of working life. DO NO Elementary/Secondary (0-12) College (1-4 or 5+)	T use retired)									
303	within iene.	Completed	12 4 building inspect	ode Name (First Middle Majden Surrame)									
21215-0036	e filed tal Hyg ked oth nt, the	Po C	John Scott Shank	Beth Irene Norris									
AD 243	2 should be and Men and Men are mark	٤	190 Informant's Name/Relationship (Type Print) 19h Mailing Address (Street and Ni	umber or Rural Route Number, City or Town, State, Zip Code) Road, Boonsboro, Maryland 21713									
Raltimore MD	Dailfillore, MID 21213-0030 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Burial 2 X Cremation 3 Removal from State Hagerstown Crematory	October 25 Hagerstown, Maryland									
Hin	mit. Pr partmer portan		21. Signature of Funeral Service Licensee 22. Name and Address of Faci	Minnich Funeral Home									
		_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	on Blvd., Hagerstown, Maryland 2174									
F	hysician Medica ⁽		failure. List only one cause on each line.										
	amine		or condition resulting in death) Due to (or as a consequence of):										
		١,	Sequentially list conditions, If any leading to home-dists b. Atherosclerotic Cardiovascular Disease Due to for as a consequence of:										
		Examino	ause. Enter Underlying Cause (Disease or injury that initiated										
	uted Id ansit	3											
_	rout, icate be executed the burial - transit the burial - transit	Modioo	UNPENDED AMENDED										
0220	certificate be executed certificate be executed nding physician and use as the burial - trans		22h Was decedent pregnant in the	23d. Date of delivery ppic pregnancy Month Day Year									
9 20	he death certific the attending ped for use as the		past 12 months: 4 Pregnant at time of death 5 Other (Specify)										
	es that the igned by e detac			Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
7	2 13 3	1-1-1		24a. Was an autopsy performed? 1 Ves 2 No 1 Ves 2 No									
6	II KEC In: The I rtificate I	3	25. Was case referred to medical 26.Piace of Des	ath (Check only one)									
7.54.5	VITAL hysician: this certif		examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other										
	- - E . < - E												
	UNVISION OF VITAL Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certif etel v filled in by the funeral director.	100	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building										
C	To the Hospital within 24 hours a To the Funeral I	ST.	4 Homicide determined (Specify) 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner as stated.									
	To th Within To th		Check this 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and concern the concern that the time, date and concern the concern that the co										
			O.C.M.E.	October 23, 2009									
5H	-10		So. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201									
- 1 '		Sta	te 31. Date filed (Month 1977) 6 2009 32. Registrar's Signature										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2122 PM 2009 Alan John Simpson ctoher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** EASTON TAIDOT Memorial HOSpital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Min 1 ▼ M 2 □ F 10/08/1945 England 64 Director 461-81-5557 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Marylan show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinations be inclined at 1 ☐Yes 2 No Director MD Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 29632 Tallulah Lane 21601 **England** by Funeral SIMPSON, ALAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baitimore, Maryland 21215-0036 1 ∐Yes 2 🔣 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "in any injury or other traumatic event, Ite Meall once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Communications Consultant Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Austin Simpson Joyce Clarkson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Simpson/wife <u> 29632 Tallulah Lane, Easton, MD</u> 21601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 10/15/2009 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 South Harrison Street, Easton, MD net the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** 0 minutes 1140 Car d disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Oyears Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

le Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of o 29c. License number 200 completed cause of death (Item 23a) (Type, Print) 30. Name and ad-10 RK 21601 mΔ gistrar's Signature 32. R State

DHMH 17 Rev 1/2001

Registrar

1- For State Registrar Physician/ 1. Decedent's Name (First, Middle,Last)	Reg. No. 20119 3551
	Date of Death 3. Time of Death
Physician/ 1. Decedent's Name (First, Middle,Last) ledical Examiner James Calvin Savoy	Month Day Year 1523 hrs
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center La Plata	Charles
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	Eoroian
Director 213-90-3595 X M 2 F 32 Yrs. Months Days Hours Min.	12/25/1976 Country Maryland
Usual Residence of Decedent	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location	1 X Yes 2 No
Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code	10g, Citizen of What Country?
10f. Zip Code 20640	
Maryland Charles Indian Head 106. Zip Code 3612 Dewey Ct 4. Article State 113. Was Decedent of Hispanic Origin? (Sp.	uscify Yes or No- 14. Race - American Indian, Black,
Maryland Charles 106. Zip Code 3612 Dewey Ct 10. Street and Number 3612 Dewey Ct 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 1 Yes, specify Cuban, Mexican, Puerto 1 Yes, Sive Year 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Sive Year 1 Yes 2X No 2 No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2X No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of voluming most of working life. Do NOT use reti 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of voluming most of working life. Do NOT use reti 1 Yes 3 Name (First, Middle, Last) 1 The Ima Dorsey/Sister 1 Adaptive Maryland Charles 1 10. Zip Code 1 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 1 Yes 2X No 1 Yes 2X No 1 Yes 2X No 1 Should at the man of the control of the properties of the control of the properties of	Rican, etc.) White, etc.
1 Yes 2X No 1 Yes 2X No specify:	Specify: Black
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	
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98 Harring de 12 Dish Washer	Restaurant
Dish Washer 12 Dish Washer 17. Father's Name (First, Middle, Last) 18. Mother's Name Mary John Henry Savoy Mary	e (First, Middle, Maiden Surname)
スペース	L. Hawkins
The part of the state of the st	Rural Route Number, City or Town, State, Zip Code)
Thelma Dorsey/Sister 3612 Dewey Ct. Ind	ian Head , MD 20640 Date
203. Method of Disposition 204. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Crematory or other place)	
Queen of Peace 11	/2/09 Helen, Maryland
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of viduring most of working life. Do NOT use retired by the part of the transmitted of the part of the	D- 3 MD 20600
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of the death. Do not enter the mode of dying, such as cardiac of the death.	ome Pa, Aquasco MD 20608 or respiratory arrest, shock, or heart Approximate Interval
failure. List only one cause on each line.	Detween Onset and
Immediate Cause (Final disease or condition resulting in death) a. NOTI—RELOCITE HYPETOSITIOTAT HYPETSTYCES Due to (or as a consequence of):	ite and azocenita
. Sequentially list conditions, b	
if any, leading to immediate Due to (or as a consequence of): Leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
d. AMENDED 23a, PII, 27, permE, g897 11/20/09	
AMENDED 23a, PII, 27, permE, g897 11/20/09) TT
TIF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	230. Date of delivery
23c. If yes, outcome of pregnancy 1	
The Femalities of the past 12 months? Yes 2 No 9 Unknown 25. If yes, dutchie of pregnancy 1 Yes 2 No 9 Unknown 27. If Femalities 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 28. If yes, dutchie of pregnancy 29. If yes, dutchie of pregnancy 20. If yes, dutchie of pregnancy 21. If yes, dutchie of pregnancy 22. If yes, dutchie of pregnancy 23. If yes, dutchie of pregnancy 23. If yes, dutchie of pregnancy 23. If yes, dutchie of pregnancy 24. If yes, dutchie of pregnancy 25. If yes, dutchie of pregnancy 26. If yes, dutchie of pregnancy 27. If yes, dutchie of pregnancy 28. If yes, dutchie of pregnancy 29. If yes, dutchie of pregnancy 29. If yes, dutchie of pregnancy 20. If yes, dutchie of pregnancy 21. If yes, dutchie of pregnancy 22. If yes, dutchie of pregnancy 23. If yes, dutchie	23e. Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cocaine intoxication, hypertension and end-stage	1 Yes 2 ✓ No 3 Probably 4 Unknown
Cocaine intoxication, hypertension and end-stage renal disease renal disease	24a. Was an 24b. Were autopsy findings available
renal disease	autopsy prior to completion of cause of performed?
The law reduires that the law reduires the law reduires the law reduires that the law reduires that the law reduires the la	1 Yes 2 No 1 Yes 2 No
26.Place of Death (Check examiner? Hospital: 1 Inpatient 2 ER/Outnatient 3 DOA Other Nurs	
examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nurs 1 Ves 2 No 2 Ref. Outpatient 3 DOA Other4 Nurs 2 ER/Outpatient 3 DOA Other4 Nurs DOA DOA Other4 Nurs DOA DOA DOA Other4 Nurs DOA DOA DOA DOA DOA DOA DOA DO	ing Home 5 Residence 6 Other: Scene
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending	
So Brending Investigation 2 Accident 2 A	28f. Location (Street and Number or Rural Route Number, City
2 2 4 2 1 1 3 Suicide Could not be	or Town, State)
4 Homicide 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered one) 4 Homicide 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated.
29b. Signature and the force of the first states. 29c. License number Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are one of the first states. 29c. License number	i at the time, date and place, and due to the cause(s)
29b. Signature and the of certifier 29c. License number	29d. Date signed (Month, Day, Year)
O.C.M.E.	October 21, 2009
30. Name and address of person who completed cause of death (Item 23a)	2.04004
Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MI	J 21201
State 31. Date filed (Month 2017 Year) 8 2009 22. Registrar's Signature Lenux D. January	
DITMINITY REV 12001 ORDER ORIGINAL	

OCME 2006

31. Date filed (Month, Day Registrar

DHMH 17 Rev 1/2001

State

Ana Rubio MD.

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Régistrar's Signature

known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** October 2009 0458 Kenneth Leroy Stephan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠**M 2□ F 61 17 1948 217-50-5820 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Westminster Director Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21158 items 23a 3925 Rinehart Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No "natural", or White Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, if a Madical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Thomas Bennett Hunter 🗘 Diesel Truck Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be Laura Amanda Click Donald Leroy Stephan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Westminster, MD 3925 Rinehart Road Lois Stephan/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ament of Hi 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/2009 Westminster, MD Meadow Branch Cem 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licentee Printer Former Falin Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed ling physician and e as the burial-trans Exam Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records,

To the Hospital or Attending Physiclan: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

WIL 10

> State Registrar

Medical

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M 211 6.

31. Date filed (Month, Day, Year)

29a. Certifier

32. Redistrar's Signature

712 Cindy Lane

1 Never Married 2 X Married

3 ☐ Widowed 4 ☐ Divorced

11. Marital Status

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

4 ☐ Homicide

Department of Important: If it any Injury or o

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

or Attending Physician: The law requires that the death certificate be executed

death.

To the Hospital within 24 hours a To the Funeral D

WIL

ours after death.

neral Director: A
filled in by the fu

Box 68760.

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

000000			
		y of Death	
8. Date of Birth (Month, Day, Ye	ear)	9. Birthp	lace (State or Foreign trv)

Month Day Year

10d. Inside City Limits 1 ☐ Yes 2% No

Approximate Interval Between Onset and Death

Year

14. Race - American Indian,

Black White etc.

23d. Date of delivery

Day

Month

Specify:

NJ

10f. Zip Code

10g. Citizen of What Country? USA 21157

12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2★☐ If Yes, Give Year or Dates: 20 No 1 □Yes 2 No Specify.

White 16b. Kind of Business/Industry
Carroll County Public

Cancer

2. Date of Death

(Month, Day, Year) Jan 30 1946

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School System Educator 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) Lillian Engelhart Raymond Compton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 712 Cindy Lane Westminster, MD 21157 E. Eugene Speck/Husband 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2x ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 10/20/2009 Hampstead, MD

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21157

Westminster, MD 412 Washington Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final NON disease or condition resulting in death)

Due to (or as a consequence of) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No

3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify)

9 I Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 2. No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work?

1 Natural 2 □ Accident 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-19-2009 DOO(06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEHARI, MD

WESTMINSTER, MD 21157 200 MEMORIAL AVE

31. Date filed (Month, Day, Year) 32. Refistrar's Signature State Registrar

determined

			For State Registrar	State of Ma	ai yiai i		tificate of		viciliai i iy	Reg. No 20)9	35513	
	Physici	an	1. Decedent's Name (First, Middle, Last,)					2. Date of De Month	Day	Vana	3. Time of Death	
1	/Medi	cal	Naomi D. Smith 4a. Facility Name (If not institution, give	otroot and number)			4h City Town	or Location of Deat		20/2009 4c. County of		7:30 AM	
	Examir	ier	Carroll Luthera					minster	1	Carroll			
-	Funeral		5. Social Security Number 6. Sec		e (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthplac	ce (State or Foreign	
	Director		219-28-6521	M 2¢⊡kF	90	Yrs.	Months Days	Hours Min.	1/4/	1919	Country	MD .	
	land bw t		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				10d	I. Inside City Limits	
	Mary a-f sho filed a	tor	MD Carrol	1	We	stmins	ster					1 □ Yes 2 No	
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Country	1?	
	23a ust b	ra	205 St. Marks Wa					158			USA		
	tems	Funeral	THE MILLION	12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.)	o- 14. Race Black	- American , White, etc		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	No		1⊡Yes 2⊠XNo	Specify:		Specify:	Whit	:e	
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	pete	15. Decedent's Edu (Specify only highest grad	cation			dent's Usual Occup	oation during most of wo	kina	16b. Kind of Bus	siness/Indu	stry	
2121	be filed within 72 ho ntal Hygiene. ed other than "natur event, the Medical.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	·+)	life. I	DO NOT use retire	d)		F	. M		
d 2	filed within Hygiene. wther than "		12 17. Father's Name (First, Middle, Last)		ľ	Keş	gistered			rederick , Maiden Surname		orial Hosp	
Maryland	should be nd Mental marked o	To Be	William W. Dudde:	rar				 Helen	Virginia	a Eckard			
ary	and and s m	-	19a. Informant's Name/Relationship (Ty			19b. Mailir	g Address (Street			per, City or Town, S	State, Zip C	ode)	
	an n 2 ne		Cheryl D. Miller	/Daughter						ter, MD 2			
Baltimore,	f i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State			sition (Name of natory or other pla		Date	20c. Location - (City or Town	n, State	
Itim	permit. Pag Department Important: I any Injury o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Lin		e Cemeter		12/04	Union	1000		
Ba	perm Depa Impo any I		21. Signature of Fulleral Service Licens			Bí	irrier-Qu	ièen Fune	ral Home	e & Crema Winfield,	mn :	P.A.	
	30.10		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of	ications that caused	the death						A	approximate aterval Between	
	Physician		Immediate Cause (Final disease or condition	Aen	vo. br	10- 10	100000000	VAL.			Ö	Inset and Death	
2	/Medical Examiner		resulting in death)	Due to (as	a consequ	ence of):	,					1	
	Examiner	_	Sequentially list conditions,	Due to (a a	onsequ	منهما	-	nj=				Ineer	
	uted I Insit	Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Arlus	L S A D		000000	m A	3.2.4	risa-		271211	
oʻ	execu an and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):	Siver	14000 14				Syam	
68760,	tificate be executed ig physician and as the burial-transit	edical		d									
39 ×	ertifica ling ph		IF FEMALE:	On If was autooms	ní n.o								
Box	attending	cian	in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal	death 3	Ectopic pregnanc Other (specify) _	у		23d. Date Mon	of delivery oth Da	ay Year	
0	The law requires that the death cer tte has been signed by the attendir tage 2 should be detached for use	Physician/N	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□Unknown			2 + = = = (
S, P	res tha igned i	by P	Part II. Other significant conditions co	ntributing to death bu	ut not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use contri	bute to the	cause of death?	
Records,	w require been si should b	ted	Collitos						1 🗆	Yes 2 No	3 Probab	oly 4 Unknown	
Sec	has bei he 2 sho	Completed							24a. Was auto	psy pi	rior to comp	y findings available pletion of cause of	
a	10 0		25.14						1□ Yes	22 No 1	eath? Yes 2	□No	
Vital	Sic Se Se Se	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatien	t 3 DOA Oth	OF A	th (Check only o		- (0'(-)		
1 Or	g Physer this eral di	 	27. Manner of Death	28a. Date of Injur	ry	28b. Time of			1	idence 6 Othe			
Sior	Attending r dearh. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Monal, Da)	y reary	Injury		Yes 2 □ No					
Division	after dear after dear Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubulding, etc			eet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	r or Rural F	Route Number,	
	soital cours a noral I		29a. Certifier 1 Certifying Phy	sician: To the best of	of my know	vledge, deati	n occurred at the ti	ime, date and place	e, and due to the	cause(s) and mar	ner as stat	ed.	
	To the Hospital or A within 24 hours after To the Funeral Dire completely illed in b	Medical		ner: On the basis of and manner sta	f examinat								
	To the Complex	Ž	29b. Signature and title of certifier				29c. Licens			29d. Date signed			
•	WIL		1 / 3/	SIX	<u> </u>		173	1949		Oct. 2	OFN	2009	
•	12		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type,	Print)	A_ h -	0	a 40	W	2000g 121157 124167	
			Treversion 170	الكاكنال	للكالل	SI WU	y sher	wer re	vie su	util le	טו. ע	MINKER	

State Registrar 31. Date filed (Month, Day, Year)

		1	For State Registrar		State of Ma	ıryland / l	Depa <i>Cer</i>	artment of H <i>tificate of L</i>	lealth Death	h and M n	ental Hy	gien Reg. N	e2009	9	3551	14
Physic	oion	,		e (First, Middle, Las	st)						2. Date of De	eath			3. Time of Deat	ith
Physic Me	cian dica			Simpson							Octobe		6, 2009		5:25 A	М
Exan	nine	r	,	. •	street and number) ntist Nurs:	ing Hom	Δ.	4b. City, Town, or Silver				1	c. County of Dea			
Funer	al		5. Social Security N	umber 6. S	ex 7. Age	(In yrs. last birt		If Under 1 Year	If Und	ler 24 Hrs.	8. Date of Bi	rth	9. B	irthplac	ce (State or For	reign
Directo	or		238-34-7	/3//	□ M 2 🔽 F	101	Yrs.	Months Days	Hours		(Month, Da larch	31 .	1908 sou	th (Carolin	ıa
ind show		. h	Usual Residence of 10a. State	10b. County		10c. City, Town	n or Lo	cation						10d	. Inside City Lir	mits
Aaryla 8a-f s tified		je	MD	Prince G	eorges	Ca	pit	ol Height	ts						1 🔀 Yes 2 🗆	□ No
a or 2 be no		<u> </u>	10e. Street and Nun	nber				10f. Zip Code				10g. C	Citizen of What C	Country	?	
th with ms 23 must		Funeral Director		ison Road			I	2074					US			
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		≥	11. Marital Status 1 ☐ Never Marr 3 🙀 Widowed	ried 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.		1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexic	can, Puerto F	city Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: B1	ite, etc		
5-0 2 hou "natu		blet	(Spe	15. Decedent's E		16a.		dent's Usual Occupa		ost of workin	ng	16b.	Kind of Busines	s Indus	try	
121 Ithin 7 ene. than		Completed	Elementary/Seco	onday (0-12)	College (1-4 or 5+	-)	life. D	O NOT use retired) Nurse					Madda-1			
led wi Hygie other		Be	17. Father's Name (First, Middle, Last)	-			Nurse	18. Mo	other's Name	(First, Middle		Medical n Surname)	•		
/lan d be fi dental arked sric ev	ا	유	Willie	Clifton					Ма	ary Ly	nn					
should and I is main aume			19a. Informant's Na	ame/Relationship (T)	vpe, Print)	- 1		ng Address (Street a				-		Zip Cod	le)	
e, R and 2 Health em 27 ther tu			Betty 1	Marcia /	Daughter			Addison 1	Rd.					<u> 207</u>		
Baltimore , permit. Page 1 and Department of Heal Important: If item any injury or other			1 🔀 Burial 2	☐ Cremation 3 ☐	Removal from State	cemeter	ry, cren	sition (Name of natory or other plac	e)		ate		Location - City of			
Baltimo permit. Page Department of Important: If any injury or	ej	ŀ	21. Signature of Fu	5 Other (Specif		Fort		COLN 2. Name and Addres	s of Fac	10/24			entwood.			
B F F E	ă		> Dle	to Man	ces			401 Blade							20722	
					plications that caused t ne cause on each line.	the death. Do r	ot ente	er the mode of dying	g, such a	as cardiac or	respiratory a	rrest,		In	pproximate terval Between	n
Pnysicial Medic	_	1	Immediate Cause (disease or condition resulting in death)		Renal Fa									Mo	nset and Death nths	h
Examin		1	Todaling in dodaly	ſ	Due to (or as a	•								V.	ars	
		<u></u>	Sequentially list co if any, leading to in cauca. Enter Under	nmediate 🚛	b. Due to (or as a									10	<u> </u>	
cuted nd transit		Examiner	Cause (Disease or that initiated events	linjury s	c		_							1		
certificate be executed rading physician and use as the burial-transit		ᇤ	resulting in death) I	Last	Due to (or as a	consequence o	01):									
/bU icate b physical sthe b	l:	edical			d											
DIVISION Of VITAI RECORDS, P.O. BOX 68. To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as			IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	: Fetal death		Ectopic pregnanc Other (specify)	έy			1.5	23d. Date of d Month	elivery Da	ay Year	
that the ned by detay		oy P	Part II. Other signif	ficant conditions c	ontributing to death bu	t not resulting i	n the u	inderlying cause giv	en in Pa	art I.	23e, Did 1	tobacco	use contribute t	to the c	ause of death?	?
dS, quires en sigl			W								1 🗆	Yes 2	2 🙀 No 3 🗆	Probab	ily 4 🗌 Unkn	nown
COF aw rec	ŀ	Completed									24a. Was	psy	prior to	comp	findings availa	
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Ital sician certifi rector		מ	25. Was case referre examiner? 1 Yes 2	1	Hospital:	- 🗅		Othe	er:	eath (Check						
OT V J Phys er this		e:	27. Manner of Death	h	28a. Date of injury		ime of	28c. Injury	/ at		ne 5 ∐ Resi 8d. Describe		6 Other (Spe	ecify)		-
on on ending sath. or: After he fun		icat	1 X Natural 2 Accident	5 Pending Investigation		Year) II	njury	M 1 🗆	? Yes 2	□No						
LIVISION OT VITAI HECOTGS, ital or Attending Physician: The law requires urs after death. ral Director: After this certificate has been sig lled in by the funeral director, page 2 should b		al Certificate:	3 Suicide 4 Homicide	6 LJ Could not b determined	e 28e. Place of Injur building, etc.	y - At home, fa (Spec <i>ify)</i>	rm, stre	eet, factory, office		2	8f. Location (City or To		nd Number or R e)	ural Ro	ute Number,	
the Hosp thin 24 hor the Fune mpleted fi	:	Medical	(Check 2 only one) 3	Medical Exami	sician: To the best of mer: On the basis of exa se Practioner: To the b	amination and/o	r invest	tigation, in my opinio death occurred at the	n, death e time, d	occurred at t late and place	the time, date	and plac ne cause	ce, and due to the e(s) and manner a	e cause is stated	d	stated.
6 wif			29b. Signature and		wayer			29c, License D1787		er			tate signed (Mon			
			30. Name and addre		completed cause of dea	ath (Item 23a) (Type, P		4			UC	tober 21	L , 2	1009	
14				n Nayer,				e. Cotta	ige (City,	MD 20	722				
S Regis	tate strai		31. Date filed (Mont) OCT 2	h, Day, Year) 2 2009	32. Registra	s Signature	ممي									
	n (n -				~~ -7 /0	7										

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sara Mae October 27, 2009 Smith 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5 Social Security Number **Funeral** 1 □ M 2 F Months Days 90 172-01-0385 22, 1919 Pennsylvania Director Jan. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedical Examination must be mattined at 1 ☐ Yes 2 ☑ No Director MD Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other than "natural", or items 23a or 2 16505 Virginia Ave. 21795 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2K No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🛛 No Specify ò Specify: 3K Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond P. Rahn Nina Jacques ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 108 Rachel's Court, Smithsburg, MD Sharon Fritsch/Daughter 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 10/30/2009 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Deatl ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. sate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a, Was an autopsy certificate 1∐Yes 2∭TNo funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation in the cause of 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Mghth, Day, Year) 29b. Signat License numbe death (Item 23a) (Type 30. Name and address of person who completed cause of TEPHEN 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08249 2009 35516 State of Maryland / Department of Health and Mental Hygiene Mark Stoneberg 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 0135 hrs Medical Examiner October 24, 2009 Mark D. Stoneberg 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Country) Months Days Hours Min Pennsylvania Director 11/29/1969 1 X M 2 F 39 163-64-4741 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County anv 1 Yes 2 No s 23a or 28a-f show : e notified at once. Bel Air Harford permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Road 2147 R Thomas Run Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. or items White, etc Armed Forces? 1 Never Married Yes Specify: White If Yes, Give Year Yes 2 X No specify. If item 27 is marked other than "natural", her traumatic event, the M-di al Examiner 3 Widowed 4 V Divorced 2 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Paving 21215-0036 12 Inspector 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Karen Stonebera John <u>Stoneberg</u> (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address S Maryland 21015 2147 R Thomas Run Road, Bel <u>Karen Stoneberg (Mother</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/26/2009 West Chester. & Co. Inc 4 Donation 5 Other Specify: 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Licensee Havre de Grace Tara C. Zellman perDVR Washington St. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death Medical a. Multiple Injuries Immediate Cause (Final disease **xamine** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial 23d, Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) the Hospital or Attending Physician: The law requires that the death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No certificate 26.Place of Death (Check only one) neral Director: After this certifi-filled in by the funeral director, 1 25. Was case referred to medica Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27 Manner of Death Driver auto auto collision Certification Oct 23, 2009 2155 hrs Yes 2 V No Natural Pending 24 hours after death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) NB 543 Goat Hill Rd./2605 Creswell Road, Bel Air, Md 3 Could not be Suicide determined (Specify) Major Road / Highway To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed Appath, Day, State Registrar

		•	For State Registrar	State of Maryland /		tment of H ficate of I			ere 0 0 9	35517
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOSEPH TYRE					2. Date of Death Month October	17,200	19 10,55 #
*	Examin Funeral Director	er	4a. Facility Name (If not institution, give str Ft. Wash Health& 5. Social Security Number 6. Sex 225-20-4208		Ctr			า	0	eath George Birthplace (State or Foreign Country) Lrginia
	ס		Usual Residence of Decedent 10a. State 10b. County Md Prince G	10c. City, To						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the N 3s or 28s-1	Funeral Director	10e. Street and Number 9909 Allen Gayle	e Drive		10f. Zip Code 20744			Og. Citizen of What	t Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Modical Examinar must be indiffed at Once.	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Xi Yes 2 ☐ No If Yes, Give Year or Dates:		s Decedent of H res, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, V	American Indian, Vhite, etc. Black
21215-0036	within 72 hou ene than "nature he Medical E	Completed by	15. Decedent's Educa (Specify only highest grade	ation completed) College (1.4or 5+) Sters Degree	(Give kir life. DC	nt's Usual Occup nd of work done NOT use retired	during most of wor d)	king C	harles chools	ess/Industry City County
Maryland 2	uld be filed Mental Hygid Irked other Itic event, II	To Be Co	17. Father's Name (First, Middle, Last) Joseph L. Tyree				18. Mother's Nan Mary Ch	ne (First, Middle, M arity	Maiden Sumame)	
e, Mary	l and 2 sho lealth and P im 27 Is me har traums		19a. Informant's Name/Relationship (Typ) Gabrielle Peace(Daughter) 99	909 Z			-	. Wash,	Md 20744
Baltimore,	it. Pages 1 rtment of P rtant: If Ite njury or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funcial Service License	moval from State New Churc	Vine ch Ce	to a or other play Baptis emetery Name and Addre	7	24.02	charles Virginia	City County 20011
Ba	Deprin		23a. Part1. Ever the disease, or complice shock, or heart failure. List only one	some						Approximate Interval Between
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8760,	icate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		dur				vva KZ
O. Box 687	death certif e attending d for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		ctopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
rds, P.	sign d be		Part II. Dther significant conditions cont	Dementiq	g in the und	erlying cause giv	ven in Part I.			te to the cause of death?
Vital Records,	10 -	Completed						24a. Was a autops perform 1 🗆 Yes 2	y prior dear	e autopsy findings available r to completion of cause of th? Yes 2 \(\) No
ot	ding Physician: Th n. After this certificate funeral director, pag	ion: To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year)	Outpatient Time of Injury	28c. Injur Wor	ner: 4 Nursing H	ath (Check only on lome 5 Reside 28d. Describe ho		Specify)
Division	or Attandition of Att	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree		103 2 110	28f. Location (St City or Town	reet and Number o n, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dirticompletely filled in In	edical	(Check only 2 Medical Exemin	icien: To the best of my knowled er: On the basis of examination and manner stated.	ige, death o and/or inve	occurred at the til stigation, in my o	me, date and place opinion, death occu	irred at the time, d	ate and place, and	due to the cause(s)
	/	×	29b. Signature and little of certifier	Solunta		-	se number		9d. Date signed (A	onth, Day, Year)
	6		Hilary K Wash.	mpleted cause of heath (Item 23a Noto 150 32. Registrar's Signature	Lin	- 1	Rd \$2	05 A.W	ash, ngto	MD 20744
	Sta Regist		31. Date filed (Month, Day, Year) OCT 2 2 2009	wer A. ba	Mes 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelibled by. Frey of All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Tinker October 18, 2009 Janet Audrey 12:45 pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🕱 F 62 Maryland 216-48-2103 04/03/1947 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show 1X Yes 2 ☐ No Baltimore Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21210 4519 Keswick Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 2 No 1 ☐ Never Married 2X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 TXNo Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) claims/collections insurance is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
De, artment of Health and Mental Hy
Im ortant: If item 27 is marked oth
am injury or other traumatic event Be Mazie Rose James George Allan Bunce ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4519 Keswick Rd., Baltimore, MD 21210 Loran C. Tinker/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/09 Salisbury Crematory Salisbury, MD 21 Si nan re of Fu_neta Service Licursee

22 Name and Address of Facility
Holloway Funeral Home Profes
501 Snow Hill Rd. Salisbury,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Namue and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd.Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final lmouar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for i Month Year 5 Other (specify) ☐Yes 2☐No 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 □ Yes typercholesterolenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Hospital or Attending Physician: **Director**: After this certific d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spaced. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perella Jr. M.D. (1982) 20 2009 Jensey 9733 Healthway Drive 31. Date filed (Month), Da State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCT Physician/ JOYCE MARIE TRICKETT 2:00PM 2009 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **E**xaminer CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -1930 1 M 2 XF MAR . 12 WEST Director VIRGINIA 579-34-2167 Usual Residence of Decedent 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director MD CHARLES WALDORF 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 10324 JANICE PLACE U.S. 20601 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ò ģ 1 Never Married 2 Married 1 ☐ Yes 27 MNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE "natural" 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed the filed of Health and Mental H item 27 is marked of 2 FRANK LEE LEEBRICK CLARA MARIE DELORME 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENA COONS/DAUGHTER 10324 JANICE PLACE WALDORF, MD 20601 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot OCTOSER 1 Burial 2XX remation 3 Removal from State METRO.Crematory 26,2009 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ MASC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a con Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month ☐ Pregnant : ☐ Unknown Pregnant at time of death 5 Other (specify) ned by the a s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral Manne Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred after death. Director: After Natural 5 Pending Accident Investigation the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Hospital 24 hours hours Medical 29a. Certifier Certifying Physician: To he best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Configure Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) of certifie 29b. Signature a

Registrar

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State

30 Name and address of c

31. Date filed (Month, Day

rson who

Year)

leted cause of death (Item 23a) (Type, Brint)

s Signature

32. Registe

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year Month **Physician** 6:47 Рм October Verdi Greene Mariorie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick **Ijamsville** 3029 Prices Distillery Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | March 6, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F 214-48-3543 North Carolina 86 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Its Medical Evanian must be mailfied at Ijamsville 1 □Yes 2 XINo Maryland Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21754 United States 3029 Prices Distillery Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 [X]No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ∐Yes 2 🔀 No Specify White Specify: ٥ 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry \$2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Ellen Kiser Nathaniel Lee Greene ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an 1021 North Garfield Street, Unit 203, Arlington, Virginia 22201 Zachary G. Warfield / Grandson item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Ignatius of Loyola 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o November 2. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Urbana, Maryland 2009 Cemeterv 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, M01433 Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DUEUMOL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the. as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 I Inknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 7 ENSI 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

UNO 31. Date filed (Month, Day,

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BAUGHMAYS LOND, MEDENILL.

ORIGINAL

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32. Registrar's Signature

EMUR TD

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND# 5,12perINF,10-27-09 EW MOD
State of Maryland / Department of Health and Mental Hygiene
2000 For State MEND#3perMD, 10-27-09, BMV, Mpm Certificate of Death Registra MEND#23a(b) perMD, 10/22/09, BMV, Mpm Certificate of Death 3. Time of Death-PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2009 October 10, JACOB J. WOLFIRE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 26, 1929 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 558-24-4590 umber **Funeral** 1 ▼ M 2 □ F New York 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show ir than "natural", or items 23a or 28a-f sho 1 □Yes 2√ No Director MD Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4919 Chevy Chase Blvd. 20815 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Korea Year or Dates: ₩₩ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: <u>გ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Info. Tech. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Mental is marked Irving Wolfire Esther Heller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 4919 Chevy Chase Blvd. Chevy Chase, MD 20815 Elaine Wolfire/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gardens Oct 13, 2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility National Funeral Home 21. Signature of Funeral Service Licensee ne01477 7482 Lee Hwy. Falls Church, VA 22042 Approximate Interval Between Onset and Death hours 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory arrest Physician /Medical Due to (or as a consequence of): Examiner Aspiration pneumonia hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-transit Parkinson's Disease years Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown To the Hospital or Attending Physician: The law require within 42 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2x No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. 12 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier aven D41507 10/10/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3301 New Mexico Ave. N.W. #202 Washington, DC 20016 Nancy Davenport MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 22 2009

Registrar

OCT

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		•	For State State Registrar	te of Maryland / Depa Cer	artment of He tificate of D		ientai Hygie Reg	. No 2009	35522
	Physicia Medic		1. Decedent's Name (First, Middle, Last) PERRY STEUART WASSOL				2. Date of Death	21 ⁴ , 2009	3. Time of Death 5:21А. м
	Examin		4a. Facility Name (if not institution, give street an WASHINGTON ADVENTIST		4b. City, Town, or L TAKOMA			4c. County of Death MONTGOM	ERY
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 [7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	920 g. Birti Ten	nplace (State or Foreign
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George	a's Adelphi	eation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
3	with the 23a or 2	Funeral Di	10e. Street and Number 3224 Powder Mill Road		10f. Zip Code 20783		10g	Citizen of What Cou United St	
0.30	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturalr, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2 Married 1 K	Yes 2 No	Vas Decedent of His i Yes, specify Cuban Yes 2 No		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
0-6121	thin /2 hour ene. than "natur he Medical	Completed by	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Deced (Give k life. DO	lent's Usual Occupat kind of work done du O NOT use retired) Onic Engi	ring most of worki	ng	b. Kind of Business I	ndustry es Government
/lang z	d be filed wi Mental Hygie arked other itic event, t	To Be (17. Father's Name (First, Middle, Last) James Charles Wassom	1	Ť		(First, Middle, Mai		es doverranci.
Man	d 2 should a alth and Me		19a. Informant's Name/Relationship (Type, Print Louise Rancourt -daug)					by or Town, State, Zip ${ m ryland}~21$	
Baltimore, Maryland 21215-0036	Page 1 and ment of He tant: If item ury or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Dispose cemetery, crem. George Wa	sition (Name of natory or other place) IShington	Cemetery	²⁰ 10/26/20	c. Location - City or 1 009 Adelph	i,Maryland
Balt	Departi Import any inj		21. Signature of Funeral Service Licensee	ranet 188	maid V. B 00 Powder	orgwardt Mill Ro	Funeral ad Beltsv	Home, PA ille, Mar	yland 20705
>	Medical Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	that caused tine death. Do not enter of each line. Le t. (or as a consequence of): Le to (or as a consequence of): Le to (or as a consequence of):	er the mode of dying,	Failu	r respiratory arrest,		Approximate Interval Between Onset and Death West
	To the Functor a continuous properties. The taw requires that the death of third withing the function of withing the function of the Functor After this certificate has been signed by the attending physic completed filled by the funeral director, page 2 should be detached for use as the b	Physician/Medical	in the past 12 months?		Ectopic pregnancy			23d. Date of deli	very Day Year
S, F.C	s been signed by	þ	Part II. Other significant conditions contributin	g to death but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Tecord	ite has been age 2 shoul	Completed					24a. Was an autopsy performe	24b. Were autoprior to code death?	opsy findings available ompletion of cause of
/Ital	this certificate has al director, page 2	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER/Outpatien	_ Other	ce of Death (Check	only one)	e 6 🗆 Other (Specif	
TO UO	er decth. rector. After this by the funeral o	Certificate: T	1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury a work?		8d. Describe how i		<i>y</i>
	s a er decth il Director A ed by the fu			Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	n 24 hour	Medical	(Check /2 Medical Examiner: On the	the best of my knowledge, death one basis of examination and/or investioner: To the best of my knowledge, d	igation, in my opinion	, death occurred at	the time, date and p	lace, and due to the ca	ause(s) and manner stated.
	within 24 hours a To the Funeral Di completed filled		29b. Signature and title of certifier MRau M		20c License r	umber	204	Data signed (Month	Day Yearl
			30. Name and address of person who completed MoBALAL WARW	1. Thin CAM DIST 1-	AVBISTEZ	40, Toka	up Poek	1MD 20	912
	Sta Registra		31. Date filed (Month, Day, Year) OCT 22 2009	33/ Registrar's Signature	des.				

09-08158 Maalik Walli Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 35523 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 21, 2009 0221 hrs Maa1ik Wali Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center g. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Country)
Maryland Months Days 12 Hours 9 2009 Oct Director N/A 1 X M 2 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Marvland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 28a-10e. Street and Number 21403 USA 184 Woods Dr. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Black Yes 2 X No specify: Specify: f Yes, Give Year Divorced Widowed event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "matinjury or other traumatic event, the Medical Exa College (1-4 or 5+) Flementary/Secondary (0-12) N/A 0 N/A Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Queleel Wali Shermia Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Md 21403 Shermia Johnson (Mother 184 Woods Dr. <u>Annapolis</u> 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Memorial Park 10-30-09 Annapolis, Md. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 2W Marrie and everse f F Willy Sons Mortuary, 821 West St. Annapolis, Md. 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death M-dical Pneumonia Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X AMENDED X UNPENDED as noted, 23a, 27, per ME g899 1/8/10 TT the attending physician ed for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ۵ Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy has performed? death? 2 No 1 🗸 Yes ✓ Yes 2 No. certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25 Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: Residence Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this ို 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending hours after death. Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide t 24 hours at (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Bniy To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2gh ature and title of certifie October 21, 2009 O.C.M.E. ame and address of person who completed cause of death (Item 23a) 0 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month / **Physician** WRIGHI ICUBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Heritage Harbour Health Center Annapolis If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Sexy 10 M 2□ F **Funeral** Days Hours Months 88 9/3/1921 228-18-1568 Nebraska Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other thaumatic event, Ite Medical Penn in the master and the master of the master and 1 ☐ Yes 2 🕅 No Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21403 87 Bay Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New and Used Elementary/Secondary (0-12) College (1-4or 5+) Automobile Sales 5+ years Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rowena Arementa Loftus James Maynard Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 87 Bay Drive, Annapolis, MD 21403 Martha S. Wright/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a. Method of Disposition important: if it any Injury or c 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-19-09 Kalas Crematory Edgewater, Maryland 4 Donation 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Service Lenser 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END ARKINGON'S AGE Rans **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne The law requires that the death certificate be executed as the burial-transi Exami and Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2DNo 1 ☐ Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

5+1 10 29b. Signature and title of certifier

State Registrar ENDEM

Name and address of person who completed cause of death (Item 23a) (Type, Print)

445) EXEMSE

29c. License number

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 for State Registrar 35525 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18 Month 10 **Physician** 2009 4:35 AM Faye L. Webb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 214 52nd Street Ocean City 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 9-4-1925 VA Director 236-36-9568 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a State 10b. County 1√Yes 2 No Director MD Worcester Ocean City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 214 52nd Street 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Stapleton 2 Georgia Sheperd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 52nd Street, Ocean City MD 21842 <u> Aaron Webb Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf MD 10-24-09 Trinity Memorial 22. Name and Address of Facility Berlin Md. 21. Signature Burbage Fareral 108 William ST. Itome plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, of heart failure. List Immediate Cause (Final Physician Honce Corrotto disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending nours after death, neral Director: Af y filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Wilson Martenia 2009 October 18. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Southern Maryland Hospital Clinton if Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Davs Hours (Month, Day 1949 Washington.D.C 577-68-4021 60 Director Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director Suitland Maryland Prince Georges 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 3309 Ryan Dr. United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 x No If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) D.C. Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ou ijury or other traumatic even Flossie Washington Rosevolt Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claranise R. Fuller/Daughter 3309 Ryan Dr. Suitland, Md. 20746 permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial 10/26/09 Suitland, Md. 22. Name and Address o Facility
Alexander S. Pope, P.A.
5538 Mariboro Pike/ Forestville, Md. Signature of Funeral Service Lig 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Te disease or condition OVONOV Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or, or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be F. Svilla Tion 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 W Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No Certificate: To 1 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

OCT 2 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

SouTheRN

29d. Date signed (Month, Day, Year)

Ave. SE - DC

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The past 12 months? Page 10	/Medic	al	Immediate Cause disease or condition resulting in death)	(Final on	plications that caused one cause on each line. a. All words are to (or as	d the death. ne. 05/LV a consequ	oficence of):	Coronal	ng, such as cardiac ry Orten	1			Approximate Interval Between Onset and Death
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			For State Registrar	State of Mar		artment of F rtificate of		Mental Hyg F	giene neg. N 2 0 0 9	35528
	_		Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ith	3. Time of Death
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-	/Medic		4a. Facility Name (If not institution, given		3011	4b. City, Town, o	or Location of Death		4c. County of Death	1 1005
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	Funeral		Prince George: 5. Social Security Number 6. 8		L (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h 9. Birth	place (State or Foreign
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9	rtifica ng pl		IF FEMALE:				De	9-11/1		
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Division of Vital Records,	o Ph ter th neral	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day,			ury at	28d. Describe	how injury occurred	ruck
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	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier t CertifyIng I	hysician: To the best of	f my knowledge, dea	ath occurred at the	time, date and plac	e, and due to the urred at the time.	cause(s) and manner as date and place, and due	stated. to the cause(s)
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			Brajendr M	israph.D	,3001 1	tospital	Dry (hever	ly, MD. 2	20.182
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	Registr	25.1		A 100	200 1 1200 00	- 1 - ·				

DHMH 17 Rev 1/2001

35529

3. Time of Death

9. Birthplace (State or Foreign Country)
WASH . , D . C .

1920

9:22P M

For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 24 2009 Physician YOW **FLORENCE** MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL CNTR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days

89

1 M 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Funeral

577-18-4309

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninat must be notified at once.

Physician

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Usual Residence of Decedent										
	10a. State 10b. County		10c. City, Town or Location								
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<u>ie</u>	10e. Street and Number				10f. Zij	p Code			10g. C	itizen of What C	ountry?
al D	13323 POPLAR H	HILL ROAD)			206	01			U. S.	Α.
uner	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Dece If Yes, spe	edent of lecify Cub	Hispanic Origin? Jan, Mexican, Pu	(Specify Yes erto Rican, e	or No- tc.)	14. Race - Am Black, Whi	
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ∐Yes 2 ☑ N If Yes, Give Year or Dates:			1 □Yes	M No	Specify:				HITE
oletec	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	edent's Usu e kind of wo DO NOT u	ork done	during most of v	working	16b. I	Kind of Business	/Industry
Com	Elementary/Secondary (0-12)	College (1-4or 5	+)	RETA	IL S	ALE				LLMARK	STORE
To Be	17. Father's Name (First, Middle, Last) FRANK H. WILD						18. Mother's N	•	Middle, Maide H PRUS		
	19a, Informant's Name/Relationship (t and Number or		-		
	GINA WILLIAMS/C	RANDDAUG			osition (Na					ocation - City o	
	1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cen	netery, cre	matory or o	other pla		VĒMBE 2009	R	ELTENH.	
	21. Signature of Funeral Service Licen	see o	M006								ICE,P.A. MD 20646
Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or company shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as c.	a conseque	() e of): nce of):	rente prosej	De De	dey s	nel Des	=1		Interval Between Onset and Death
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	leath 3	□ Ectopic □ Other (s				_	23d. Date of do	elivery Day Year
by Ph	Part II. Other significant conditions c	ontributing to death be	ut not result	ing in the ι	underlying	cause gi	ven in Part I.	236			to the cause of death?
b	Mesura Mil	wills							1 ☐ Yes	2 □ No 3 N	Probably 4 Unknow
Complet								-	a. Was an autopsy performed? Yes 2	prior to death?	autopsy findings available completion of cause of cause of 2 No
Be (25. Was case referred to medical	_				-	26. Place of I	Death (Check	k only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2DE	R/Outpatie	ent 3 🗆 D	OA Ot	her: 4 \(\tau_\text{Nursing}	a Home 5	Residence	6 □Other (Sp	necify)
on: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ry 2	8b. Time of Injury	of	28c. Inju Wo	ry at	-	scribe how inj		cony
Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At hom c. (Specify)	ne, farm, st	M treet, factor]Yes 2∏No	28f. Loc City	ation (Street a	and Number or I te)	Rural Route Number,
dical C	29a. Certifler 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner sta	f examination	ledge, dea on and/or i	ith occurre	d at the on, in my	time, date and pl opinion, death o	lace, and due	e to the cause e time, date a	(s) and manner nd place, and di	as stated. ue to the cause(s)
Se	29b. Signature and title of certifier				29	9c. Licen	se number		29d. E	ate signed (Mo	nth, Day, Year)

Months

DHMH 17 Rev 1/2001

State Registrar

20601

To the H within 24 To the F complete	Medi
Sta Registr	
DHMH 17 Rev 1/2	00

			Please	Ctets of M						_				
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2009 355											35530			
		_	Registrar Decedent's Name (First, Middle, La	st)		001	incate or	7-	2. Date of Death 3.					
	Physici		Alexan		-	Zhelez	nuah		Month	October 20, 2009 5:				
T	/Medic		4a. Facility Name (If not institution, give			merez		r Location of Death		4c. County of Dea				
	LX		4521 East-West	Hiahwau			E	Bethesda		Mor	ıtgomery			
	Funeral		5. Social Security Number 6. 5		x 7. Age (In yrs. last birthday)			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 22,	Year) 9. B	rthplace (State or Foreign Country)			
	Director		550-63-5240 Usual Residence of Decedent	- W 2 23 1	95	Yrs.			June 22,	1914	Russia			
	land ow		10a, State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits			
	Mary Fied s	tor	Maryland Montgon	10 J. U			Be.	thesda			1 □Yes 2 No			
	th the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	Country?			
	23a ust b	ral	4521 East-West	Highway				20814			S.A.			
	er deg tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh				
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2 🔀 I If Yes, Give Year or Dates:	NO.		1 □Yes 2 🛣 No	Specify:		Specify:	Caucasian			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show with the Mychen Examiner must be notified at	per	15. Decedent's E. (Specify only highest gra			16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines				
215	hin 7: an "n	ple	(Specify only highest gra Elementary/Secondary (0-12)		i+)	(Give life.	kind of work done DO NOT use retired	d)	king					
	ygien ygien her th	Completed		College (1-4or 5			Physic				cine			
ind	be filk	Be	17. Father's Name (First, Middle, Last						ne (First, Middle, M					
r ∑l	d Mer narke natic	2	Ivan An			405 84-15	- A			Letskaya nber, City or Town, State, Zip Code)				
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "secol Examiner must be notified at		19a. Informant's Name/Relationship (Jane Yufik - Day							, Maryland				
ē,	t Hea f Hea ftem 2		20a. Method of Disposition	ignet	20b. P		sition (Name of matory or other place			20c. Location - City of				
9	Pages ento nt: If ry or		1 🗓 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special					i	2/2009	Olney, Ma	ruland			
alti	permit. Pages 1 and 3 Department of Health Important; If Item 27 any Injury or other tr once.		21. Signature of Funeral Service Lice		12000	22	2. Name and Addre	ss of Facility Hi	nes-Rina	ldi Funero	l Home, Inc.			
8	B B E B) alay	_ Vonn	علال	11	800 New	Hampshire	e Ave., S	Silver Spr	ing, MD 20904			
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	prications that caused one cause on each li	the death	n. Do not ent	ter the mode of dyi	ng, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death			
· Ku	Physician	Immediate Cause (Final disease or condition resulting in death) a. Non Hodgkins Lymphoma Stage IV									5 months			
no.			Due to (or as a consequence of):											
	2	e	Sequentially list conditions, if any, leading to immediate	b. Brain Tumor Due to (or as a consequence of):										
B	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
760, 1	ite be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):								
876	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical	•	d										
x 68	leath certificate I attending physic	Physician/Medi	IF FEMALE:	23c. If yes, outcome	of progno	2004								
Вох	atten for us	cjan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	☐ Ectopic pregnanc ☐ Other (specify) _	су		23d. Date of d Month				
0	that the dended by the a	ıysi	1 □ Yes 2 🗷 No 9 □ Unknown	g 🗆 Unknown										
Э,	s that gned b	by Pi	Part II. Other significant conditions	_	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?			
ord	w requires been sign should be		Atrial Fibrill	Cation					1 □ Ye	es 2 No 3	Probably 4K Unknown			
ecc	e law re has be le 2 sho	plet							24a. Was a					
Atrial Fibrillation Atrial Fibrillation Atrial Fibrillation Atrial Fibrillation Atrial Fibrillation 25. Was case referred to medical examiner? 1 Yes 2									perform 1 ☐ Yes		? es 2 No			
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	ath (Check only on					
ō	Phys r this ral dir	.To	1 ☐ Yes 2 🗶 No 27. Manner of Death	28a. Date of Inju		ER/Outpatie 28b. Time o	IL 3 L DOA			ence 6 Other (Sp ow injury occurred	pecify)			
Division	th. th. Afte	tjon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	28a. Date of Injury (Month, Day, Year) 28b. Time of light of lig						e now injury occurred			
Visi	Atter r dea ector by the	ifica	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At ho	ome, farm, str	eet, factory, office			treet and Number or	Rural Route Number,			
Ö	tal or s afte al Dir	Certification;	4 Horricide	building, et	c. (<i>apecii</i>)	y)			City or Town	n, state)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Vithi To th	M	29b. Signature and title of certifier		//	1	29c. Licens			9d. Date signed (Mo				
	7		1 Dise	ere la	1			05921	74	10-2	1-09			
			30. Name and address of person who					uito 410	Rothor	da Manula	nd 20814			
	Sta	ite	Giselle Mery, M.T 31. Date filed (Month, Day, Year) OCT 22 200	33. Registr	ar's Signa	ture		110	, Decreed	in cyrea	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registr	ar	OCT 22 200	19 Centua	1	. par	Ked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16, 2009 Joseph Albert Ziegler October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 412 Taney Drive Taneytown Carroll If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1X M 2 ☐ F 219-30-4878 75 Director 02/22/1934 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Modical Examiner must be notified at MD 1 XYes 2 ☐ No Director Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 Taney Drive 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: 1951 – 55 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Inspector Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert S. Ziegler Anna Doggett ပ 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Harvey-Ziegler 412 Taney Drive Taneytown, MD Department of Health Important; if item 27 any Injury or other to once. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licen 136 E. Baltimore St. Taneytown, MD 21787 Approximate Interval Between Onset and Death 2sa, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 127 (2110 121-36 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? 2 No perform 2 🗆 No 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Darke

66

MALLAN

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35532 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3 Year 1:30 PM Ellen Aisenberg Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Feb 22. Months Days Hours 219-16-4837 84 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 840 W. 40th Street #557 21211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 24 No Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: white 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ art teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Rosenstock Tillie Miller . Page 1 and 2 should ment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22213 Creekview Drive Gaithersburg, MD Jeanne A. Witt/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9 1 Burial 2 Cremation 3 Removal from State permit. Page Department (Important: If any injury or 4 □ Donation 5 🗖 Other (Specify) in state Anatomy Gifts Registry 11/4/2009 Hanover, Maryland 21. Signat Day Funeral State Licent State and Address of Facility and 655 W. Baltimore Street Baltimore. MD 21201 23a. Part 1∫ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line.
ediate Cause (Final ase or condition

Cerebrovascular Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner tibrillation unknown Atria 1 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, unknown burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1-*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carter

Union Memorial Hospital

32. Registrar's Signatu

AT 2438946

E. University Pkwy

November, 2, 2009

Bullimore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** : 30 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Parkury NA LEVIER If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number 6. Sex Funeral 1 □ M 2 🗗 Months Days Hours Min. Director MRYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Extra direct must be motified at 28a-f show 1 Pres 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLAC If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary/(0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's (First, Middle, Last) Be Robert Harris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MAYLAND NA HOUR MININ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeration lice 22. Name and Address of Facility BAIT, MD. 21229 23a. Part J. F. tof the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest Immediate 2 use (Final disease or condition resulting in death) **Physician** CONCUESTIVE /Medical Due to (or as a consequence of): Examiner witerm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed YOUTIM and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 1 ☐Yes 2 🗷 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MISTOUN 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) 8 CUTTOUST. SILITE 308 Ultost 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

09-08489

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35534

James Anderson	1-	For State		Certificate	of Death	orna, riyg.o.	Reg. No).						
Physician/	Re	egistrar Decedent's Name (First, Middle,Last)					e of Death		3. Time of Death	٦				
Medical Examine	8	Jam	es 1	Inder			ember 2, 2	2009	0710 hrs	_				
(a. Facility Name (if not institution, give stre			4b. City, Town, or Location	on of Death		c. County of	Death					
		Johns Hopkins Hospital			Baltimore		150 05 00			-				
Funeral	5	. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)			8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Md							
Director	0	219-52-6349 17M 2 F 60 Yrs. 103-23-174-7 COUNTY) 17-101												
	L	Isual Residence of Decedent		City, Town or Loc					10d. Inside City Limi	ts				
' any	1	0a. State 10b. County		1 Ves 2 N	40									
Maryland 28a-f show	5	Md. NIF		10	a (Timor	<u>e</u>	10g. Citizen of What Country?							
the Maryland at onc.	3 1	0e. Street and Number	1		10f. Zip Code	21	log. c	/]	CA					
3a or otifie			adway		Was Decedent of Hispanic	Origin 2 (Specify)	Ves or No-	14 Race -	American Indian, Black,	\dashv				
r death with or items 23. must be no	1 2	1. Marital Status 1 Never Married 2 Married	. Was Decedent Ever Armed Forces?	in U.S. 13.	f Yes, specify Cuban, Mexi	ican, Puerto Rican	, etc.)	White,		- [
or its	5		Yes 2 1	No 1	Yes 2 No spe	ecify:		Specify: BIACIC						
ral", Ininer	⋧┞	3 Widowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Dates:	ed) 16a, Dece	tent's Usual Occupation (G	Give kind of work d	one 16t	16b. Kind of Business/Industry						
"nati	ompieted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of working life. DO N	NOT use retired)	,	Joh	n Hopkin	0				
36 hin 72 than sdical		12th	NIA	Env	iron menta		h.		Huspital					
d with	5	17. Father's Name (First, Middle, Last)	. 1			other's Name (First		- 1	. 2	ŀ				
215 be file ntal H ked c	ဗ္ဗ	Thomas,	Anderso	n		Virgini		eph		-				
21 ould 1 d Mer s man tic ev	o٦	19a, Informant's Name/Relationship (Type	, Print)	19b. Ma	iling Address (Street and		Route Number	City or Town	d, 2123/					
MD d 2 sh lth an n 27 i		Rovina Anders	on- Wire	20h Place of Dis	position (Name of cemeter				City or Town, State	-				
rre, slan frea If iter	1	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory o	r other place)	11-10-	19	N. 411	& MILLS IM	7				
mo Page nent c		4 Donation 5 Other Specify:		Varriso	in forest				<u> </u>	2				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Γ	21. Signature of Funetal Service Licensee 22. Name and Address of Facility 270 Fred HILT on Facility												
	_	Approximate Interval												
Physician 'Vacitati	1	fallure Vist only one cause on each line.												
aminer	Ì	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):												
	-	h.												
	<u>ĕ</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C. Disease or injury that initiated												
cuted		events resulting in death) Last Due to (or as a consequence or). d.												
execut an and al - trai	sician/Medical	X UNPENDED 23a,PII,27,permE, g897 11/13/09 TT												
60, ate be exe hysician	e le		23c. If yes, outcome of		CIMILY 6077	22/20/02		23d. Date of						
rtifica	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2		Ectopic pregnancy		Month	Day Year					
Box 6876 he death certificat the attending ph	sici	1 Yes 2 No 9 Unknown	Pregnant at time	e of death 5	Other (Specify)			 						
that the death oned by the att	Ph.	Part II. Other significant conditions of		ut not resulting in	the underlying cause giver	n in Part I.			ribute to the cause of death					
P.O.	의	Chronic obstructi					1 Yes	2 No 3	Probably 4 V Unkno	wn				
cords, P.O. aw requires that the has been signed by should be detach	ted						24a. Was an autopsy		Were autopsy findings avai prior to completion of cause	lable e of				
corc law re has be	Completed	urinary tract dis	ease				perform	ed?	death? ✓ Yes 2 No.					
Rec The icate	اق				26 Place of	Death (Check only			100 100					
Vital Recol	Be	25. Was case referred to medical examiner?	spital: 1 Inpatient	2 FR/Outp:		ner ₄ Nursing H		esidence 6	Other:					
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reteart. Reterring the secretificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	ဠ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year		e of Injury 28c. Injury a	at Work? 28	d. Describe ho	w injury occu	rred					
n of ding Ph. . After e funeral	ö	1 X Natural 5 Pending	(Month, Day,Year)	1 Yes	2 No								
ivisior or Attend after death Director:	cati	2 Accident Investigation	28e. Place of Injur	y - At home, farm	, street, factory, office build	ding, etc. 28			ber or Rural Route Number,	City				
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Specify) or Town, State)												
- E & B E		29a Certifier	n: To the best of my k	nowledge, death	occurred at the time, date	and place, and du	e to the cause	(s) and mann	er as stated.					
To the Hos within 24 h Completely	Medical	one) 2 Medical Examiner:	On the basis of examir and manner stated.	nation and/or inve	estigation, in my opinion, de	eath occurred at th	e time, date a	nu piace, and	dde to the eddee(e)					
To with	Me	29b. Signature and title of certifier	number	29d. Date signed (Month, Day, Year) November 3, 2009										
		Carde At	allai		O.C.M.	E.		Novembe						
		30. Name and address of person who co	ompleted cause of dea	th (Item 23a)	0.	- MD 04004								
10			t Medical Exami		enn Street, Baltimore	e, MD 21201								
1	ate		32. Rigistrar's	Signature	back									
Regist	rar	NOV 0 5 20	UN JUNE	~ p.	700-									

ORIGINAL

For State

35535

	Physicia /Medic Examin	al
j		
	Funeral	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Registr	ar					Cei	uncale	OI L	Jealii			Reg. No.	_ 0 0		- 0 0	
sician edical	1. Decedent	s Name	(First, Middle,		LEIGH	BAKE	R					2. Date of De Month OCT	ath Day	2009 ^Y	ear		of Death
ner	4a. Facility N	4b. City, Town, or Location of Death BETHESDA					c. County of Death MONTGOMERY										
	5. Social Second None	curity No	umber	6. Sex 1 □ M 2	ex 7. Age (In yrs. last birthday). ☐ M 2 🌠 F Yrs.			If Under 1 Months E	Year Days	r If Under 24 Hrs. 8. Date construction Min. 12 Oct.			Day, Year) Coun			lace (State stry)	e or Foreign
	Usual Residence of Decedent																
tor	10a. State 10b. County 10c Florida Okaloosa						Oc. City, Town or Location Destin							10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
Directo	10e. Street a			oca		100	10f. Zip Code			a 10g				g. Citizen of What Country?			
	281	Vi	nnings	Way B	lvd. A	pt. 1	1101	325	541				U.	S.A.			
Funeral	11. Marital S	tatus	ed 2□ Marri	12. W	as Decedent rmed Forces? ☐Yes 2 🗓	Ever in U.	No			as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric			Ricán, etc.) Black, W			American Indian, White, etc.	
ò	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:						1	□Yes 2∑	(INo	Specify:			Specify: White				
eted		/Snec	15. Decedent'	s Education	nleted)			dent's Usual C			at of work	rina	16b. Kir	nd of Busin	ess/Inc	Justry	
Completed	Elementa		ndary (0-12)		ollege (1-4or	5+)		N/A						N/	'A		
lo Be (17. Father's Name (First, Middle, Last) Tyler Lee Baker							18. Mother's Name (First, Middle, Maiden Surname) Marci Porter								
Ì			me/Relationsh		•		195 Mailin 28 I	g Address (S	Street	and Numb	er or Rui	ral Route Numb Apt.	er City of	Town, Sta	ate, Zip	Code)	
	20a. Method	of Disp		-			Place of Dispo	sition (Name	of er plac	e)		Date		cation - Cit			
		-	☐Cremation 5 ☐Other (Sp		al from State) Ia	rkláwn rk	Memor	ial	L	11-0	1-2009	Hamp	oton,	Vi	rgini	La
21. Signature of Fluneral Service Licensee 22. Name and Address of Facility Claytor Rollins Funeral Home 836 Poquoson Ave., Poquoson, VA 23												3662	,				
	23a. Part 1.	Enter th	ne disease, or	complication	ns that cause	d the deati			_					VII 45	7002	Approxim	nate Between
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition LETHAL CONGENITAL ANOMALIES													nd Death			
	resulting in		"	a	Due to (or as			IAL AN	OFIE	MILLO					_		
	Cognoptials	list cor	aditions	b													
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying																
cam	that initiated	с								-							
edic				d													
/sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown						aldeath 3⊑	leath 3 Ectopic pregnancy					23d. Date of delivery Month Day Year			Year	
Phy	Part II. Other significant conditions contributing to death but not resulting in the un-							nderlying cause given in Part I. 23e. Did tot					tobacco u	pacco use contribute to the cause of death?			
d by									1 🗆 '					res 2万No 3☐ Probably 4☐ Unknown			
Completed												24a. Was an 24b. Were autopsy findings			igs available		
dmc												auto perf	psy ormed?	prid dea	r to couth?	mpletion o	of cause of
ပ္ပ	25. Was ca	se refer	red to medical							26 Plac	e of Dea		2 No	1 L	Yes	2 No	
Ö	examine 1 🔲 Yes	er?		Hospit	al: 1 🕅 Inpat	ient 2 🗆	Other:				ce of Death <i>(Check only one)</i> Nursing Home 5 ☐ Residence 6 ☐ Other <i>(S</i> ,				(Specif	fy)	
_	27. Manner	of Deat	h		Ba. Date of Inj	ury	28b. Time of		. Injur	γ at			cribe how injury occurred				
atio	1 Nat 2 Acc		5 ☐ Pending investig		(Month, Day, Year) Injury			М	Work? M 1 ☐ Yes								
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)							et, factory, office 28f.			28f. Location City or To	3f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical C	29a. Certific (Check one)			Examiner:		of examina						e, and due to th rred at the time					se(s)
Mec		ure and	title of certifier	^		-4.44.		29c. l	_icens	se number			29d. Dat	e signed (Month,	Day, Year	r)
	Contralling						0101242311 (VA)				DC	tober	- 2	9,2	009		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATE E. OLIVER LT MC USN BETHESDA MD 20889-5600											R					
ate	31. Date file	NUT	05 20	09 /	32. Regist	rar's Signa	ature	and and									
rar		JUNE 1	0000	- /		10.	1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM#*PERFH, G897, 11/10/09 WS State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ Day Bruc Hen 09 :39AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Renaissance Gardens Catonsville Baltimore 8. Date of Birt 2/14/1912 Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Months 213-01-2526 06/14/1912 Maryland Director 97 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Catonsville Baltimore 1 🗆 Yes 2 🔼 No MD or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 709 Maiden Choice Lane RGT420 21228 United States items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ō Completed by ☐ Yes 2☐ No Maryland 21215-0036 hours after 1 ☐ Yes 2 XNo Specify: If Yes, Give "natural", 3 Midowed 4 ☐ Divorced Specify. Year or Dates traumatic event, the Madical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Il Hygiene. other than " Figmentary/Seconday (0-12) College (1-4 or 5+) Printing Company Printer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Frederick G. Bruckner Elizabeth Reigger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2125 Bellvale Road, Fallston, Maryland 21047 Lisa A. Gardner (Executor) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 11/10/2009 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition neumone Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of: and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital Other: 1 🗌 Yes 2 1 No <u>ء</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ロイヤ37 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 5 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last) Physician/ I allow M. Pray and	of Death	Reg. N	2009	35537
		2. Date of Death Month	Day Year	3. Time of Death
Medical Johnny M. Bryant			2009	11:07 A M
-AC-MANACA	Town, or Location of Death 1timore	4	lc. County of Death NA	1
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months 7. Age (In yrs. last birthday) Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year)	g. Birti Cou	hplace (State or Foreign
Heugl Residence of Decedent				
Position 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits X X X Yes 2 □ No
Baltimore 106. Street and Number	Code	100.0	Citizen of What Cou	
the sea to be se	21212	109.	USA	anti y :
MD NA Baltimore 10c. City, Town or Location Baltimore 10f. Ziput 4435 Old York Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Marital Status 15. Was Decedent Ever in U.S. 16. City, Town or Location Baltimore 10f. Ziput	ent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	ican Indian,
Armed Forces? If Yes, specifing a graph of the specific of the	fy Cuban, Mexican, Puerto l X No Specify:	rican, etc.j	Black, White	.⇔African rican
15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	Occupation done during most of working	16b.	Kind of Business I	
The state of the s	retired)	<u> </u>		
Truck Dr	1	(First, Middle, Maider		rucking Co
Figure 2 2 P Johnny Bryant, Jr.		e Bryant	ii Gairiaine)	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address ((Street and Number or Rura	Route Number, City of	or Town, State, Zip	Code)
Earl Mae Bryant - Mother 4435 Old	York Road			21212
Truck Dr 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. City	e of her place) rest 11-1	l l	Location - City or ings Mi	Town, State $11\mathrm{s}$, $$ MD
21. Signature of Funeral Service Licensee 22. Name and 6.38 No.	Address of Facility Wy Gilmor St			
23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode shock, or heart failure. List only on cause on each line.			1	Approximate Interval Between Onset and Death
Physician/ Medical Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) a. 6 pm resulting fine from Bodere	emia			Onset and Death
Examiner Sequentially list conditions, b. He position failure				
if any, leading to immediate Due to (or as a consequence of):	kla i			5
per pure present of the present of t	iny		1,	
p of a purifical and a purific				
IF FEMALE:				
FFMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic properties 1 Ves 2 No 9 Unknown 2 Unknown 2 Unknown 2 Ves 2 Ves 2 Ves 3 Ves 4 Ves			23d. Date of deli Month	very Day Year
to the page of the	ause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
an signe the large of the large		1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Ad sed of		24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of
E SE	26. Place of Death (Check	1 Yes 2	No 1 ☐ Yes	2 No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Do.	Other:	ne 5 Residence	6 ☐ Other (Specia	fv)
27. Manner of Death 1 Natural 29 Accident 1 Natural 29 Accident 1 Natural 29 Accident 3 Suicide 4 Homicide 28 Date of injury (Month, Day, Year) 28 Date of injury (Month, Day, Year) 28 Date of injury M 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident 3 Suicide 4 Homicide 28 Date of injury Accident Accident 3 Suicide 4 Homicide 28 Date of injury Accident Accident 3 Suicide 4 Homicide 28 Date of injury Accident Accident 3 Suicide 4 Homicide 28 Date of injury Accident Acc		28d. Describe how inju		,
3 Suicide 6 Coold not be 28e. Place of Injury - At home, farm, street, factory,		28f. Location (Street a City or Town, Stat		al Route Number,
4 be see a second and seed of mighty - At norme, farm, street, factory, building, etc. (Specify)				ted.
The state of the s	ny opinion, death occurred at			
The state of the s	ny opinion, death occurred at led at the time, date and place License number	e, and due to the cause	e(s) and manner as s rate signed (Month,	stated. Day, Year)
A COLONIA	ny opinion, death occurred at ed at the time, date and place License number	e, and due to the cause	e(s) and manner as state signed (Month,	Day, Year)
A COLONIA	ny opinion, death occurred at led at the time, date and place License number	e, and due to the cause	e(s) and manner as state signed (Month,	Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death Examiner itan 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No 10e. Street and Numbe 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ementia Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditi**ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 100d 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Certificate: To 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature apprititle of certifier 29c. License number 29d. Date signed (Month, Day, Year) accoluceolin Kham MA 11.4.09 00061272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 cock raven Blvd, RMB5205 Saceduddun Khan GS H 32: Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	tate of Marylan	•	artment of H rtificate of L			jiene eg. No. 20	N 9	35539
	Physici	an	1. Decedent's Name (First, Middle, Last)	n _o .				Date of Deat Month	th Day		3. Time of Death 9:15 A M
	/Medic Examir	cal	Ned Ronald 4a. Facility Name (If not institution, give stre		wman	4b. City. Town, or	Location of Death	Novembe	4c. County of		9:13 A M
	Examir	ier	586 Nolview Court	,		Glen Bu			Anne		e1
	Funeral Director		5. Social Security Number 6. Sex 208-24-2501	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 2	7,1933	Count	ace (State or Foreign ry) Lame town , P
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	a-f sh	ctor	MD Anne Arunde	el Gle	n Burn	ie					1 □Yes 2 K No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Count	ry?
	sath w	eral	586 Nolview Court	Man Donadont Francis III	0 1401	21061	ii- O-i-i-2 (C	eit Waa an Na	U.S.A		a ladian
036	urs after de al", or item examinar i	by	1 ☐ Never Married 2 ☐ Married	Was Decedent Ever in U. Armed Forces? 1∑∏es 2 ☐ No if Yes, Give Year or Dates:		was Decedent of Hi f Yes, specify Cuba I □Yes 2 X \\0	spanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)		- America k, White, et Whi	ic.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be routified at once.	Completed	15. Decedent's Education (Specify only highest grade control Elementary/Secondary (0-12)	on mpleted) College (1-4or 5+)	(Give life. I		luring most of workii)	ng	16b. Kind of Bus		
2	illed w Hygiel ther ti		17. Father's Name (First, Middle, Last)	J	Inve	ntory Spe	cialist 18. Mother's Name	(First Middle I	U.S. Maiden Surname		nment
Maryland	ld be lental ked o	To Be	Hiram Bowma	211			Doroth	, , ,		7 Matte	22
ary	shou and M s mar	٦	19a. Informant's Name/Relationship (Type.		19b. Mailir	g Address (Street a	and Number or Rura	~			
Σ,	and 2 lealth m 27 I		Mrs. Lisa Culley / I				ok Road				
Baltimore,	nt of ⊢ if Ite		20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Rem	oval from State 20b. P	Place of Dispo cemetery, cren	sition (Name of natory or other place	NOV 2		20c. Location - 0		
İFİ	artmel ortant injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service Licensee	At	lantic	Cremator	y 2009 ss of Facility Sir		Glen Bu		
Ba	Dep Jany) MAST Z	M01220							e, MD 2106
	Physician		23a. If rt 1. Enter the discussion, complication shock, or heart failure. List hip one commediate Cause (Flina disease or condition								Approximate Interval Between Onset and Death
1	/Medical		resulting in death)	Due to (or as a consequ	uence of):	0 7-10					
	Examiner	j.	Sequentially list conditions, b. —	Due to (or as a consequ	mer of	eus, v				(of years
1/2	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ger 6e 01).						
, O	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
68760,	cate by	dical	d								
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date Mor	e of deliver	y Day Year
	s that ned by deta	by Ph	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	bacco use contri	bute to the	e cause of death?
ords	equire en sig ould b							€ DXe	s 2 □ No	3 ☐ Proba	ably 4 Unknown
Division of Vital Records,	The law rate has be page 2 shu	Completed						24a. Was a autops perform	sy p med? d	Vere autop rior to com eath? Yes 2	sy findings available opletion of cause of
Vita	Iclan: certific ector,	Be	25. Was case referred to medical examiner?	ital		Other	26. Place of Death		-		
of	Phys er this eral dir	۲: T	I les 2 Parto	1 ∐ Inpatient 2 ∐ 8a. Date of Injury	ER/Outpatier 28b. Time of	t 3 DOA Othe	4 LI Nursing Hoi		ence 6 Othe	,,)
ion	nding ath. r: Afte e fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	? Yes 2□No	iod. Booding In	on injury cooding		
Divis	tal or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	8e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Si City or Town	treet and Numbern, State)	r or Rural	Route Number,
	the Hospit in 24 hour the Funer pletely fill	Medical (an: To the best of my kno On the basis of examina and manner stated.							
		A	29b. Signature and title of certifier		7	29c. License			9d. Date signed		
	Sta	to	30. Name and address of person who complete D. W. M. I. 31. Date filed (Month, Day, Year)	eted cause of death (Item) \(\text{VOOS} \) (32. Registrar's Signa	iroun	HWY #	100 G	en B	11-0 Unie	M	21001
	Registr		NOV 0 5 2009		A. 4	arke					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ROSA BELL 2009 12:30PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY <u>TAKOMA</u> PARK ADVENTIST HOSPITAL WASHINGTON 8. Date of Birth (Month, Day, 1.2/7/10 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🗓 F Months 73 577-58-7681 NORTH 935 CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No WASHINGTON DC 10g. Citizen of What Country?
UNITED STATES 10f. Zip Code 10e. Street and Number Funeral 20002 1511 TRINADAD AVE NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: BLACK If Yes, Give Completed 3X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) $\overset{\text{Elementary/Seconday (0-12)}}{12}$ PRIVATE DOMESTIC Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LINNA WARD ဂ္ WILLIE PENDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1511 TRINADAD AVE., NE WASH., DC 20002 BARBARA BELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/10/09 WASHINGTON, DC 4 Donation 5 Other (Specify) GLENWOOD CEMETERY! 21. Signati re of Funeral Service Li 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC 20002 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. U Approximate Interval Between Onset and Death ly one cause on each li Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) Yes 2 X No is certificate has been signed by the a director, page 2 should be detached in 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown rior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an has performed Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🔀 No မ ER/Outpatient 3 DOA Marient 2 this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 \square Pending Matural 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check <u>3</u>

State Registrar

31. Date filed (Month, Day, Year)

only one)

ALCA

ss of person who completed caus

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D45660

State Registrar ANGELA

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

HOLLY

2449

32. Registrar's Signatur

AVE.

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100

ANNAPOLIS,

21401

30. Name and addres of person who completed cause of death (Um 23a) (Type, Print)

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		Please	Type or Prin					-		•	
		For State Registrar	State of Ma	•		rtment of F tificate of I		Mental F	lygien Reg. N		3551,2
		Decedent's Name (First, Middle, Las	st)					2. Date of	Death		3. Time of Death
Physicia /Medic		Edward Ray Co	nnelly					111/4	4/20	09 Year	8:00 A M
Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of De	ath	40	c. County of Death	1
<i>_</i>		1820 Mayfield	Avenue			Halet			Baltimore		
Funeral		5. Social Security Number 6. So	E3 o 🗆 =	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of (Month,	Birth <i>Day, Year</i> 26/19	9. Birth	place (State or Foreign intry)
Director		217-12-8950 1 Usual Residence of Decedent	X W Z Z ,	86	Yrs.			10/2	26/19	923 Ma:	ryland
and	ł	10a. State 10b. County		10c. City, Town	n or Loca	ation					10d. Inside City Limits
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the round	Director	10e. Street and Number]		10f. Zip Code			10g. C	itizen of What Cou	intry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene with the Han "natural", or Items 23a or 28a-f show ant, the Madical Examinar must be redified at	무	1820 Mayfield A	Avenue			212	29			USA	
deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin?	(Specify Yes or	No-	14. Race - Amer Black, White	
after or ite		1 ☐ Never Married 2 💢 Married	1 X Yes 2 ☐ I If Yes, Give	No		Tes, specify odbi	Specify:	erto i noari, etc.,			White
ours	d by	3 Widowed 4 Divorced	Year or Dates:							ареспу.	
72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de c <i>ompleted)</i>	16a.	(Give ki	ent's Usual Occup ind of work done O NOT use retired	durina most of w	vorking	16b. l	Kind of Business/I	ndustry
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Hygie ther		17. Father's Name (First, Middle, Last)		<u>I</u>	ATT Y	Man	18. Mother's N	lame (First, Midd			
d be ental ced o	Be c	John Joseph Cor					Els	ie Ben	son		
shouls nd Me mart	ပ	19a. Informant's Name/Relationship		19b.	. Mailing	Address (Street	and Number or	Rural Route Nui	mber, City	or Town, State, Z	ip Code)
nd 2 sulth an alth an 27 is		Katherine E. Conne								MD 2122	
f Hear tem other		20a. Method of Disposition	, ,			ition (Name of atory or other place		Date		Location - City or T	
Pages ent o nt: If I		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Specify				k Cemete		7/2009	Ba]	Ltimore,	Maryland
mit. F partm contar ibjui	Ì	21. Signature of Funeral Service Licen								eral Home	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene." important: If Item 27 is marked other than "natural" any injury or other traumatic event, It is Medical Expone.		KIN C	il								and 21229
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/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	di):	oma					TPTYLO
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the de	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	a time of death	5□	Other (specify) _					
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uires uires d be	d by							1	Yes	2 X No 3 □ Pro	obably 4 🗆 Unknown
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The lav	티							– aı	utopsy erformed?	prior to death?	completion of cause of
iclan: Th certificate ector, pag	ပိ	25. Was case referred to medical					26 Place of F	1 ☐ Ye Death (Check on		lo 1 □Yes	2 🗆 No
Attending Physician: r death. ector: After this certific. by the funeral director;	. B	examiner?	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Ou	ıtnatient	3 DOA Oth	or:	1.4		6 ☐ Other (Spec	sifu)
g Ph	-	27. Manner of Death	28a. Date of Inju	ury 28b.	Time of	28c. Inju				ury occurred	ouy)
ath.	atio	1 Natural 5 Pending 2 Accident investigation		iy, rear)	irijury		k? Yes 2□No				
Afte ecto by th	iji	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	ury - At home, fa	ırm, stre	et, factory, office			n (Street a	and Number or Ru	ral Route Number,
tal or safte	Certification:	- Indinioide	building, et	o. (opcony)				Only or	iom, oa		
To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	nysician: To the best niner: On the basis of	of my knowledge	e, death	occurred at the ti	ime, date and pl	ace, and due to	the cause	(s) and manner as	stated. to the cause(s)
the H nin 24 the F	Medical	one)	and manner st								
Vitt	2	29b. Signature and title of certifier				29c. Licens	se number			Date signed (Monti	n, Day, Year)
2 1		1,00					525		11-	5-09	
1118		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, P		2.0	10 1111	10.1	0115	5
0		31. Date filed (Month, Day, Year)	32 Monietr	rar's Signature	Ter	JUNE !	BALTI	noxe	100	12/20	
Sta Registra		31. Date filed (Month, Day, Year) 0 5 2	009	A A	B	all					
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09-08539

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ancis Cutchins	1- For State Certific Registrar	ment of Health and Mental ficate of Death	Reg	No. 2009 3554
Physician/ ledical Examiner	Decedent's Name (First, Middle,Last) Francis Neal Cutchins		2. Date of Death Month October 31,	3. Time of Death
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
	Union Memorial Hospital	Baltimore		n/a
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last			(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Virginia
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d Inside City Limits
Aaryland 28a-f show 1 at once. ector	MD Baltimore Ca	tonsville	-	1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
with the is 23a o	719 Maiden Choice Lane, BR6	09 21228 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - American Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	1 Never Married 2 X Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pur		White, etc.
safter ral", o	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: White
"natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		6b. Kind of Business/Industry
5-0036 led within 72 hour 1/ygiene. other than "aatt the Medical Exar Completed	12 0	Executive		Chemical & Oil
15-0 iled will Hygie d other the M			ame (First, Middle, Ma	·
21215-0036 ould be filed within 7 1 Mental Hygiene. s marked other than it event, the Medical TO Be Comple	John W. Cutchins 19a. Informant's Name/Relationship (Type, Print)		or Rural Route Numb	er, City or Town, State, Zip Code) 21228
MD 21 d 2 should th and Me in 27 is ma umatic ev	Margaret F. Cutchins / Wife	719 Maiden Choice L		
re, les land free free free free free free free fre		ce of Disposition (Name of cemetery, matory or other place)	Date	20c. Location - City or Town, State
Baltimore, oermit. Pages I ar Department of Her Important: If ite Injury or other tr	4 Donation 5 Other Specify: Bayv			Baltimore, Maryland
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental 1 Important: If item 27 is marked injury or other traumatic event, TO Be	2) Sign ture of Funeral Service Licensee	22. Name and Address of Facility	Jubbard Fu	neral Home, Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the death. D			
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive at	therosclerotic cardi	ovascular	disease Between Onset and Death
aminer	or condition resulting in death) Due to (or as a consequence of):			
9	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
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Box 6876 te death certificat the attending ph ned for use as the hysician/IV	past 12 months? 4 Pregnant at time of death	2	grandy	34,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I	23e Did toba	acco use contribute to the cause of death?
ires that the signed by I be detach	Hip fracture; end stage renal			2 No 3 Probably 4 ✔ Unknown
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nding th. : Afte e fune	1 Natural (Month, Day, Year)	1 Yes 2 Y Ne	28d. Describe ho fall	w injury occurred
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Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	4 Homicide determined (Specify) hospita	<u></u>	laltimore	e, MD
Divi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and			•
To the comproduction of the co	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	Carre Leclan	O.C.M.E.		November 4, 2009
12	30. Name and address of person who completed cause of death (Item 23			
$\mathcal{N}_{\sqrt{}}$	Carol Allan, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21	201	
State Registrar				
DHMH 17 Rev 1/2001		ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, per Fh g897 11/10/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Stephen **Physician** 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show notified at Ballimore MDirector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 21234 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Black Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sommercil 10th 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 20b. Place of Disposition (Name of 20c. Location -20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponded Source (15). Immediate Cause (Final disease or condition resulting in death) DROAN **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ABUSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No MIL 24a. Was an autopsy certificate MEDATITIS 1∐ Yes 2**∏**2ÎNo Vital 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ō 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 24 hours af er death. Funeral Director: After 5 Pending investigation (Month, Day Year) Injury Division Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10/30/2009 RES 000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD

32 Registrar's Signature

MAMEDOV

31. Date filed (Month, Day, Year)

05

2009

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

Day

MD 21238

1 Yes 2 No

Registrar DHMH 17 Rev 1/2001

State

5601

SAMARITAN

LOCH RAVEN BLVD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MRER Day Chapman 201019 Jacob Dreher Ø9:57AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Baltimore Towson . Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Days March 26, 217-10-3298 93 **Director** Usual Residence of Decedent show 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 12261 Roundwood Road, Unit 1414 within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married þ "natural", or Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 - Widowed 4 - Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic even pe Lemuel Hezekiah Dreher Chapman Clara Mabel Easler permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther G. Chapman / Wife 12261 Roundwood Road, Unit 1414, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Hilltop Service Corp. 11/4/2009 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PROBABLE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to tot as a consequence on or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed l director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No certificate 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within. the 29b. Signature and title of certifier 29c. License number D15452 November 2, 2009 30. Name and address of person who completed cause of death tem 23a) (Type, Print) BESSEN 7601 TIMOTHY OSLER DRIVE TOWSON, MARYLAND strar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Amend #5 per Fh 9897 11/13/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day <u>1:3</u>0 ^{рм} **Physician** Luther Darden James 2009 11 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1211 Fourwinds Way Essex Balto 5. Social Security Number 6485 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours 1-1-1946 Director 245-68-85 63 N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Musical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Balto Essex 1 and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene. em 27 Is marked other than "notimen" 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 Fourwinds Way 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes X□No Black Specify: 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Peerless Imports 12th grade N/ Laborer Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Willie Darden Mittie Coley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Fourwinds Way Essex, MD 21221 Leona Darden-Wife item permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State Elmwood Cemetery 11-7-09 Goldsboro, N.C. 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ala 1101 E. North Avenue Balto, MD 21202 wa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** co.lite disease or condition resulting in death) /Medical Due to (or as a consequence? Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 \ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 þ 4 Unknown 1 🗌 Yes 2 No 3 Probably been : Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No r this certificate has b rral director, page 2 sl 24a. Was an autopsy performed? 1 □ Yes 2 □ No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ ₩0 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier
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Check o 29a. Certifier and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller nam Kan Strut Surte Gesterown filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of	Marylan		artment of			ntal Hyg	giene			
-			Registrar Certificate of Death							leg. No. 2	200	35	5547
	Physic	ian	1. Decedent's Name (First, Middle, Last) Roy O. Davis						Date of Dea Month	Day	Year	3. Time	of Death
	/Medi		4a. Facility Name (If not institution, give street and numb	arl .		4b. City, Town,	or Looption		vemb		09	5:30) P M
	Exami	ner	1625 North Warwick A	•						4c. Coun	ty of Death ∧		
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	Director		217-03-0320	98	Yrs.	Months Days	Hours	Min. 04	– 0 7 – 1	l 1	MD		
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	be filed within 72 hours after death with the Maryland ntal Hygiene. and the Han "natural", or items 23a or 28a-f show event, it a Medical Examinat must be institled at	Funeral	11. Marital Status 12. Was Decede Armed Force			Vas Decedent of Yes, specify Cub		rigin? (Specify	Yes or No-	14 B:	ace - Americ	an Indian	
is 36	or it	by Fu	1 Never Married 2 Married 1 Yes 2	X No		Yes 2X No			n, etc.)	BI	ack, White,	^{etc.} Afr	ican
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	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		Alberta Davis - Wife 20a. Method of Disposition	not Di		N. War							21217
Dec Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		1 Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te ND	metery, crem	ition (Name of atory or other pla	ice)	Date	1	20c. Location	-		
Ē	nit. Partme artme ortani Injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	MD		'1 Cem.		1-07-0		Laurel Ineral			Ā
Ba	permit. Departn Importa any Inju	1 3	Simela Jones					r Stre					
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	tificat ng phy as th	ledical											
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	nysici nis ce direc	0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa	tient 2 ☐ E	R/Outpatient	3 □ DOA Oth		of Death (Che ursing Home			her (Specifi	d)	
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only 2 Medical Examiner: On the basis and manner	of examination	on and/or inve	estigation, in my o	opinion, dea	ith occurred at	the time, da	iuse(s) and m ite and place,	anner as st and due to	the cause	(s)
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			I rigor keele	y		DH	16H	H	1	VOV	4.8	9	
	SV		00. Name and address of person who completed cause o	deam (Item 2	23a) (Type, P	18		1	7 7	110	1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death JOVEM 5 12000 Paul Joseph Dunn 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death (=)en Ishrn Baltimore Washington Med Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F 174-22-4558 79 Mar 17, 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1366 River Road 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 51-71 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Air Force 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Albert Dunn Adele Marie Sprague 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Dunn/spouse 1366 River Road Crownsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from Stat 4 ☑ Dopation 5 ☐ Other (Specify) 21. Sign for from Harvice Licens Ronald & Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) Due to (or as a consequence of). 200 neck Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ No 9 Unknown ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes d to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Examiner

Physician/Medical

Be Completed by

Certification: To

ca

29a. Certifier

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

δ

Completed

Be

r than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be execute sician and burial-trans attending physician for use as the buria ned by the detached signed be det

Box

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Division of Vital Records,

page 2 should certificate funeral director, After death. within 24 hours after deatl

To the Funeral Director: filled in by the

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25.		s ca mine Yes	222	eferi	
	· 🗀	163	,	- 4	140

27. Manner of Death

5 ☐ Pending investigation 1 Natural 2 Accident 3 Suicide

6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 □Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

> 0 B

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

COF 31. Date filed (Month, Day, Year)

5

32 Registrar's Signature

State Registrar

completely

30

Registrar

State

Hospital

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwest

5

31. Date filed (Month, Day, Year,

DOO68783

5401 Old Court Read Fandal

10-31-2009

21133

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35550 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Bertie May Emge October 8:40 AM M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1<u>919</u> Months Days Hours Sept 13 1 □ M 2 😿 F Director 90 212-12-2787 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7700 York Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) salesperson <u>department store</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Henry Emge Eva May Banister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Brazier/niece 2206 Cloverdale Drive Fallston, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ron 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi 29a. Certifier (Check 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

berson who completed cause of death (Item 23a) (Type, Print)

NOV 05

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		aryland	d / Depa	artment of F tificate of D	Peath	Mental Hy	giene Reg. No	2009	3555I
Physician	/	1. Decedent's Name (First, Middle, L. James Rowla	<i>'</i>	on				2. Date of De Month		3, 2009	3. Time of Death 11:30 A ^M
Medica Examine		4a. Facility Name (if not institution, given				4b. City, Town, or	Location of Deat			County of Death	11:30 A**
<i>2</i>	ı	Gilchrist Hosp			_	Tows	son			Baltimo	re
Funeral Director		242-20-1508	Sex 7. Ag 1 X M 2 □ F	e (In yrs. la 86	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	9. Birthp Count NC	lace (State or Foreign ry)
nd how	-	Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Lo	cation					0d. Inside City Limits
farylar Ba-f s tiffed	Funeral Director	MD Balt:	imore		Towso					ľ	1 ☐ Yes 2 🗶 No
a or 2	<u> </u>	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Coun	try?
th with ms 23 must		800 Southerly Ro					1286			USA	
te &	≥	 11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced 	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	It	Vas Decedent of Hir f Yes, specify Cubar ☐ Yes 2 🗶 No	n, Mexican, Puert	pecify Yes or No- to Rican, etc.)		14. Race - America Black, White, e Specify: Whit	etc.
15-C	Completed	15. Decedent's (Specify only highest of	Education trade completed)		(Give I	lent's Usual Occupa kind of work done d		rking	16b. K	(ind of Business Inc	lustry
/tthin /	5	Elementary/Seconday (0-12)	College (1-4 or 5	i+)		O NOT use retired) Accountar	nt			Stee1	
filled w filled w I Hygi I othe vent,	90	17. Father's Name (First, Middle, Last						me (First, Middle,	Maiden		
ylar Id be Mente	2	James Robert El	ington		,		Mami	e Riddic	k Ro	wland	
Maryland 2 should be filed Ith and Mental Hy 77 is marked oth traumatic event		19a. Informant's Name/Relationship	** * *							Town, State, Zip C	· 1
and 2 and 2 Health tem 2	1/2	Audrey Ellington 20a. Method of Disposition	<u>/Wife</u>	20b Pl		Southerly sition (Name of	Road #			MD 2128 ocation - City or To	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once,		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of F	eify)	ce	emetery, cren antic	natory or other place Crematory	4,	ember 2009		Glen Bu	rnie, MD
Dep Dep any any any any	I		chael J. F	lag1e	Le:	mmon Fune	eral Home	e of Dul	aney	Valley, MD 21093	Inc.
	1	23a. Part 1. Enter the disease, or on shock, or heart failure. List only	nplications that caused one cause on each line	the death					_		Approximate Interval Between
Physician/	- 1	Immediate Cause (Final disease or condition resulting in death)	Sdr	oke						- 1	Onset and Death
Medical Examiner	1	resulting in death)	Due to (or as a	a conseque	ence of):						3
		Sequentially list conditions, if any, leading to immediate	b Due to (or as a	t consequi	anea oi):					- 8	
kecuted and al-transit		cause. Enter Underlying Cause (Disease or iinjury that initiated events	C								
urisia e		resulting in death) Last	Due to (or as a	a conseque	ence of):						
760 icate be e			d								
Box 68 death certi e attendin ed for use		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	у		3	23d. Date of delive Month	ry Day Year
P.O. I that the ned by the detache		Part II. Other significant conditions	contributing to death b	ut not resu	liting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco u	use contribute to the	e cause of death?
dS, quires an sign		Diabetes				<u> </u>		1 🗆 '	Yes 2	□ No 3 □ Prob	ably 4 Unknown
Records, P. The law requires the rate has been signed page 2 should be de		previous so	rokes					24a. Was		prior to con	sy findings available appletion of cause of
i: The licate h								1 🗆 Yes	rmed? 2 N	death?	2 🗆 No
Sician sectification inector	5	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		-0.0	Othe	r:			→	Hespia
of VI g Physi er this c eral dir		27. Manner of Death	28a. Date of injur	у [2	R/Outpatien 28b. Time of	28c. Injury	at	lome 5 ☐ Resident Properties 1		Other (Specify) y occurred	rispice
eath. or: Aft. he fun	2	1 Natural 5 Pending 2 Accident Investigation		; rear)	injury	M 1 🗆	? Yes 2 □ No				
Division of Vital Records, tal or Attending Physician: The law requires are death. al Director: After this certificate has been signed in by the funeral director, page 2 should be contificated.		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			ne, farm, stre	et, factory, office		28f. Location (S City or Tow		d Number or Rural I	Route Number,
the Hospita in 24 hours the Funeral	O DOM	(Check 2 Medical Exar	ysician: To the best of niner: On the basis of exrse Practioner: To the l	amination	and/or investi	igation, in my opinior	n, death occurred a	at the time, date a	nd place	, and due to the cau	se(s) and manner stated.
To with	2	29b. Signature and title of certifier	But, (Ri				number (9194			te signed (Month, D	
10	3	30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type, P		n, MI	D 21	204		
State		1. Date filed (Month, Day, Year)	32. Regiona	r's Signatu	ire	1					
Registrar		<u>GUYUN</u>	2000	Wa.	8.40	park					· · · · · · · · · · · · · · · · · · ·

DHMH 17 Rev 7/2009

ELLINGTON, JAMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35552 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year John Feit Barron 2009 рм November Medical **て・**ちて 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 213-66-7797 1 **▼** M 2 □ F Months Days Hours Min Director 54 10/9/1955 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show anote. Injury or other traumatic event, the Medical Examination on the manufacture of the medical Examination of 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7614 Spruce Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give by Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Landfill Manager Landfill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Delores Moroz ഉ Clarence Wayne Feit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 E. Boundary Ave. Rosedale, MD 21237 Barron J. Feit II Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 11/6/2009 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licenses Dorota Marshall La eu Marsha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequen e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the daying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Unknown the 1 ☐ Yes 2 L 9 ☐ Unknown been signed by a should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a Was an performe certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 6 1 Chris 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined hin 24 hours af the Funeral Di npleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** <u> 2006</u> reorde /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9. Birthplace (State or Foreign Westminst If Under 1 Year | If Under 24 H der Date of Birth (Month, Day, Year) 5. Social Security Number UNK Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F 80 Yrs. April 9 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be mailful at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 2178 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☒ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) th 5 Techanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Bruce seorge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2016 Frantz Niece rissandra City or Town, State 20c. Locatto 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or - 19 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee IAM 1232 Midvalley Dr PA 18434 Jessup 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death men **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year for 1 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 1 d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 2 No certificate 1 □Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death. To the Funeral Director: Atter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Mosth, Day, Year) 29c. License number 29b. Signatore and title of certified Rominister, MD

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh 8898 12/11/09 TT/ #5perFH, G898, 12/15/09 WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 48^{₽ м} Joyce Goodman 3 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Balto Social Security Number 219-42-0129 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 20 If Under 1 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Months Days Hours Min. Country) 65 Director 1944 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2216 Aiken Street 21218 U S items ? Α within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ò 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced 4 Divorced Completed Specify: Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Disabled Disabled Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Ments John Goodman Department of Health and Meni Important: If item 27 is marke any injury or other traumatic o Dorothy E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Aiken Street Mark Alston-Son Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State King Memorial Pk 11-9-09 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset an Death Physician, disease or condition Medical resulting in death) Due to (or a la consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 ther (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a d.tifle of certifie icense number 32009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arzo N Parson M 128 Ν 32. Registrar's signature State Registrar

09-08521 Tracy Gunn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

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25 Signature of Fundral Service Licenses Dorocha Marshall Maryl Land Cremation Services 22 Signature of Fundral Services 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of gring, such as dardisc or respiratory arrest, shock, or head Between Onset and Death 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of gring, such as dardisc or respiratory arrest, shock, or head Between Onset and Death 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of gring, such as dardisc or respiratory arrest, shock, or head Between Onset and Death 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of gring, such as dardisc or respiratory arrest, shock, or head Between Onset and Death 23 Part 24 Part 24 Part 24 Part 25	Pages I and nent of Healt ant: If iten or other trai		1 Burial 2 X Cremation 3 Removal from State crematory	or other place) purney Crem. 1							
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29b. Signature and title of certifier O.C.M.E. November 3, 2009 30. Name and address of person who completed cause of death (Item 23a)	te law require te has been sig ge 2 should b	mpleted			autopsy perform	prior to death?	completion of cause of				
29b. Signature and title of certifier O.C.M.E. November 3, 2009 30. Name and address of person who completed cause of death (Item 23a)	g Physician: T fter this certifice neral director, pa	To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Out	patient 3 DOA Other; one of Injury 28c. Injury at Work?	Nursing Home 5 R		er:				
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29b. Signature and title of certifier O.C.M.E. November 3, 2009 30. Name and address of person who completed cause of death (Item 23a)	the Hospi thin 24 hou the Funer mpletely fi		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat one) Medical Examiner:On the basis of examination and/or in	vestigation, in my opinion, death occ	urred at the time, date at	nd place, and due to	The cause(s)				
11. Add Dann Street Politimore MD 21201	To with	Me									
	HV		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD	21201						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>009</u> Physician/ Month 11:30a M Nov. Melvina D Greene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Woods <u>Baltimore</u> Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb. 22,1928 Hours Country) Maryland 1 □ M 2 🔀 F 81 219-20-6566 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Completed by Funeral Director .28a-f MD Baltimore Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 9 10g, Citizen of What Country? 8620 Kelso Drive Apt. A318 21221 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 9 Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Amtrak 10 <u>Ticket Agent</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lemuel Ayres Alice Archer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 1304 Clover Valley Way UnitB Edgewood, MD Mary Ayres/Sister in Law f Health a item 27 i injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Page 1 Baltimore NAtional 11/5/09 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly FUneral Home of Essex 21221 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6 110 disease or condition Medical resulting in death) aconsequence of): Examiner dne Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Laureral Director: After this certificate has been signed by the attending physicia the dilled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2 **1** No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 유 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Aursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0061 truvel NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOPPAINE OF ORI-AWUAH, MD. 5430 LAMPBELL BLVD, BALTIMORE MD 21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 21 per fh, g897, 11/05/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Janet Gaebel October Marie 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Regional George's Hospital Laure Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 92 540-09-1395 Yrs Director May 9, 1917 OR Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show OR Multnomah Portland Portland 1 □Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3035 N.E. Jarrett Street 97211 USA Funeral is 1 and 2 should be filed within 72 hours after dea of Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, Item Neufor Exprint All Items. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Painting Supply Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard George Quiney Helen Pauline Scholz ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum Diane L. Davidson - daughter 4405 N.E. 23rd Avenue, Portland, OR 97211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 🙀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) River View Cemetery 10/17/2009 Portland, OR 22. Name and Address of Facility Charles L. Stevens Funeral Home 21. Signature of Funeral Service Licenses Victor P. Doda, Jr. per DVR Inc., 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Cerebral Infarct Examine Thromboembolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): requires that the death certificate be executed Exami Atria Fibri and burial-t Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) ned by the a P.O. 9 Unknown 9 Unknown signed by the period of the period of the details of the details of the details of the period of the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s been si should t Were autopsy findings available prior to completion of cause of death? aw page 2 autopsy performe certificate Division of Vital 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Physician; After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0012962 October

State Registrar Zorayda

31. Date filed (Month, Day, Year)

Laurel Regional

Hospital

7300 Van Dusen Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Lee-Llacer, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 9,15-19b / Per all partition of Health and Merital Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician GUTTER MINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS HOSPITAL PRING MONTGOMERY NER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number **Funeral** Year) 1 □ M 2 🗗 F New York Director 117-18-614 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MONTGOMER SILVER 1asc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ,09 1790 DEAN 24 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ⋧ Specify: HITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry education Elementary/Secondary (0-12) College (1-4or 5+) art teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Grafman Fay Trachenberg ပ NOW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12909 Dean Rd. Silver Spring Md. 20906 19a. Informant's Name/Relationship (Type. Print) Fred Gutter/spouse Spring Md. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (\$pecify) 3 Removal from State te Licensee 21. Signature of Euneral Second ROTIA 10 22. Name and Address of Facility Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AIXOGYH) /Medical Due to (or as a consequence of): Examiner LEURIAI B FFUSION MALIGNAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit METS BOCKE MAISAVO Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 14No 1 □ Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/29/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WINIFRED FB

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

WD

32. Registrar's Signature

FOREST GLEN RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G897 11/10/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Vincent Conrad Hillen 03 200 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 01/24/1994 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Integrate 1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evantive must be notified at once. **Funeral Director** 1 XYes 2 No MD Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5630 Stevens Forest Road, Apt. 245 21045 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Student N/A 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be 17. Father's Name (First, Middle, Last) David Hillen Karen Fitzpatrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Hillen/Mother 5630 Stevens Forest Road, Apt.245, Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Cremation Services 11/04/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee Zama M01197 7522 Connelley Drive, Ste.N, Hanover, MD 21076 . Hardesty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4INSTEM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burital-transi P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

09-08496 John Hicks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ın Hicks		- For State	of Maryland /		ment of licate of i		Mental F		eg. No.	0 0 9 3 5 5 6
Physiciar dical Examin	n/	egistrar I. Decedent's Name (First, Middle,Last	John Mel		icks, J	ſr.		2. Date of Dea Month Novembe		3. Time of Death 1050 hrs
,		### ##################################	street and number)	UK.	41	o. City, Town, or L Baltimore	ocation of Dea	th	4c. County of I	/A
Funeral Director		5. Social Security Number 6. Se 1 X	x 7. Age	e (In yrs. last	birthday) 56 Yrs.	If Under 1 Year Months Days	Foreign M X D XZT X XID			
d now any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits 1 X Yes 2 No
	Directo	MARYLAND N/A 10e. Street and Number 2463 ETTING STR		Fires in II S		10f. Zip Code	217		U.S.A.	t Country? American Indian, Black,
death wi	by Funeral		If Yes, Give Year or Dates:	XX No	If Ye	es, specify Cuban,	Mexican, Puer specify:	rto Rican, etc.)	White, Specify:]	etc. BLACK
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Menhal Hygiene. Important: If item 27 is marked other than "matural", injury or other traumatic event, the Medical Examiner.	ompleted t									
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last JOHN M HICKS SR. 19a. Informant's Name/Relationship (1			19b. Mailing		DORT	S SMITH	, Maiden Surname) umber, City or Town	ı, State, Zip Code)
ore, MD es I and 2 sho of Health and If Item 27 is		DORIS HICKS/ MOT 20a. Method of Disposition 1 XXBurial 2 Cremation 3		tate cre	ace of Dispos ematory or oth	ition (Name of cen ner place)	netery,	Date		City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify 21. Signature rall Security	see		22. N W J	206 W NOT	of Facility BROWN RTH AVE	NUE	ry funera	ORE, MARYLAND L HOME P.A.
Physician 'Medical caminer	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ach line.	disord sequence of):	ler :	ne mode of dying,				Between Onset and Death
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	XUNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	AMENDED 23 23c. If yes, outcome 1 Live birth	1, per a,27,p	ME g8 permE, ancy 2 Fe	3898 12/17 9898 12/ etal death 3 ther (Specify)	//09 TT /9/09 T	<u>"T</u>	23d. Date of Month	delivery Day Year
that the death of the detection of the atterdetect of the attend of the atterdetect of the atterdetect of the atterdetect of th	by Physic	1 Yes 2 No 9 Unknow Part II. Other significant conditions	g Unknown		<u> </u>		given in Part I.			ibute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. taal or Attending Physician: The law requires that th its after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed t							24a. W	as an 24b. V	Were autopsy findings available orior to completion of cause of death?
/ital Rec ysician: The nis certificate director, page	o Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6 Other: Scene								✓ Other: Scene
Sion of \\ vttending Phy death. ctor: After the	Certification: To	27. Manner of Death 2 X Naturel 2 X Accident Pending Investigs	28a. Date of Ir (Month, Day 1999	/,Year)	28b. Time of		Yes 2 No	subj	ect fell In (Street and Numb	red per or Rural Route Number, City
Hospi 24 hou Funer etely fil		(Choon only	ed (Specify)	nk my knowledd	re death occi	urred at the time.	date and place	or Town unk , and due to the o	n, State) ause(s) and manne	er as stated.
To the within To the comple	Medical	one) 2 Medical Examin 29b. Signature and title of certifier	and manner state	d.	205t	29c. Licen	se number			ned (Month, Day, Year)
		30. Name and address of person wh Victor Weedn MD JD	Assistant Medic	al Examir	ner 111	Penn Street,	Baltimore,	MD 21201		
S Regis	tate tra	$\sim = 00$		trar's Signatu	. pa	Mal				

Andre Haney, Jr.
09-08352 PI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK	UNK		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2009 3556												
	-		Registrar 1. Decedent's Name (First, Midd	le Last)	Cert	uncate or	Dealii			2.	Date of Dea	eg. No.	- 4	3. Time	3556 of Death
ledi	Physici ical Exam			Andre	Haney,					(Month October 2	Day Yea 8, 2009	r	1042	2 hrs
			4a. Facility Name (if not institution Johns Hopkins Hospi		umber)	4	b. City, Tov Baltimo		cation of I	Death		4c. County of	or Death		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under		If Under 2	_	8. Date of Bir	th(MM/DD/YYYY	9. Birt	hplace (S	State or
	Director		213-76-8071	1X M 2 F	4	16 yrs.	Months	Days	Hours	Min.	5-18	-1963		untry)	ND
	'n		Usual Residence of Decedent		100 City	Town or Location	20							10d. Ins	ide City Limits
	ow any		10a. State 10b. County				JII								res 2 No
	Aaryland 28a-f show 1 at once.	ctor	MD 10e. Street and Number	N/A	<u>Ba</u>	lto	10f. Zip C	ode				0g. Citizen of Wi	nat Cour	41	
1	he Mai or 28 iffed a	Director	911 E. Chase	Street			2.	120	2			US	A		Ì
1	, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	uneral	11. Marital Status		ecedent Ever in U.	S. 13. Was	s Decedent es, specify	of Hispa	anıc Origin	n? (Spec	cify Yes or No		- Ameri e, etc.	ican India	n, Black,
	death or ite	Fune	1 X Never Married 2 N	1 Yes	2 X No			_		201011	, 5,51			lack	
	s after rral", miner	by	15 Decedent's Education (Specific only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry								-				
	2 hour matt	eted	Elementary/Secondary (0-12)		(1-4 or 5+)		ost of worki							Tab.	
	1215-0036 Id be filed within 72 hours afte dental Hygiene. narked other than "natural", event, the Medical Examines	ompleted	12th grade	9	N/A	(Cook					Howa		Joni	ison
	Hygie dothe	ပိ			-			11		,		Maiden Surname))		
	21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, th. Medica		Andre K. Haney Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb							er or Ru	Cana	mber, City or Tov	vn, State	e, Zip Co	de)
	MD :	-	Athea MCCul			911	E. (Cha	se S			alto,	MD	2120)2
	Tore, MD 21215-003 ages 1 and 2 should be filed within nt of Health and Mental Hygiene. tt: If item 27 is marked other th other traumatic event, the Med	'	20a. Method of Disposition 1 X Burial 2 Crematic	n a Demoval	from State	Place of Dispos crematory or oth	ner place)				Date	20c. Location	- City or	Town, S	tate
	Pages nent of ant: I		4 Donation 5 Other 5	Specify:	Tr	rinity	Cem	ete	ry					, MI	
	Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		21 Signatur of Funeral Service	e Licensee			lame and A					East F		WD	22202
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock											Appro	21202 eximate Interval
	Physician / Ledical		failure. List only one caus	e on each line.	tic (mor									Betw	een Onset and Death
	tamine		Immediate Cause (Final diseas or condition resulting in death)		a consequence o		u dic	OHOS	Inc	OMIC	acton				
		<u>_</u>	Sequentially list conditions,	b.	a consequence o	nf):	_				_			+-	
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	ited d ansit	Examiner	events resulting in death) Last		s a consequence o	of):					_				
	be executed sician and urial - transit	dical	X UNPENDED	AMENDE	23a,27	,28a-f,	per M	E g8	397 1	1/10	/09 T				
	x 68760 h certificate b tending physi use as the bu] ₩	IF FEMALE; 23b. Was decedent pregnant in	the	s, outcome of preg	nancy	etal death	3	Ectopic			23d. Date of Month	of delive	ry Day	Year
	Box 68760 e death certificate l the attending physical for use as the bi	Physician/Me	past 12 months?	4 Pre	gnant at time of de		ther (Speci	ify) _		p. 03				•	1
	that the deat ned by the at detached for	hys			known	trian in Aba	and advised	001100 0	ivon in Por	et I	23e Did	tobacco use con	tribute to	o the cau	se of death?
	P.O. es that the	à	Part II. Other significant cond	iltions contributing	to death but not r	resulting in the t	underlying	cause y	iven in rai			es 2 V No 3			
	cords, P law requires t has been sign 2 should be c	Completed								-	24a. Wa	s an 24b			ndings available on of cause of
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	tal Rectant: The certificate ector, page	ပိ	25. Was case referred to media	cal			2		of Death (Check o					
	Vita hysicla this ce	To B	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2 🗸						Home 5	Residence 6	Oth	er:	
	ing Physician: The l After this certificate l	٦	27. Manner of Death 1 Natural 5 Pe	(Mo	ate of Injury nth, Day,Year)	28b. Time of	·		ryatWork' ∕es 2 🛣	- 1	^{28d.} Describ unknow	e how injury occu	irred		
_	Sior Attend r death ector: by the	gaţi			10/28/09 lace of Injury - At h	Fd 9:5					28f. Location	(Street and Num	nber or F	Rural Rou	ite Number, City
1	DIVISION Spital or Attendin hours after death. meral Director: /	ertification:		termined (Speci		d in al		000	a	- 1	or Town	State) 2400 nore, MD	Gre	eenmo	ount Ave
	Univision of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate him 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physical physicial has been signed by the attending physical physical director, page 2 should be detached for use as the b	၂ပ	29a. Certifier	Physician: To the last	pest of my knowled	dge, death occu	irred at the	time, da	ate and pla	ace, and	due to the ca	use(s) and mann	ier as st	ated.	e(s)
	To the Hosy within 24 hc To the Fun-	Medical		and manne	er stated.	and/or investiga			e number			29d. Date sig			
		2	29b Signature and title of certi	1/1/2/2	Man 198	80		O.C.I				October 2	29, 20	09	
			30. Name and address of pers	on who completed o	ause of death (Iter	m 23a)									
			Victor Weedn MD JI	O Assistant I	Medical Exam	iner 111	Penn Sti	reet, E	altimore	e, MD :	21201				
		State	31. Date filed (Month, Pay 2004)	2009	Registrar's Sign	ure par	4								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		1	State of Maryland / Department of Health and State State Registrar State of Maryland / Department of Health and Certificate of Death		Reg. No	2009	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month, 10/2		no Year	3. Time of Death 1:15 P M
	/Medic	al	Elizabeth N. Hopkins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea			. County of Death	
	Examin	er	300 7th Avenue, N.E. Glen Burnie			Anne Ar	rundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year Months Days Hours Mir		Birth Day, Year) 1922	9. Birth Cou	nplace (State or Foreign untry) ryland
	70		Usual Residence of Decedent				10d. Inside City Limits
	arylar show	7	MD Anne Arundel Glen Burnie				1 ☐ Yes 2 🌠 No
	the M	recto	MD Anne Arundel Glen Burnle 10e. Street and Number 10f. Zip Code		10g. Ci	itizen of What Cou	untry?
	3a or	io le	300 7th Avenue, N.E. 21060		US.	A	
	r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	No-	14. Race - Amer Black, White	
350	hin 72 hours after death with the Maryland B. "natural", or items 23a or 28a-f show Madical Evertainer must be notified at	by	1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No If Yes, Give 1 □ Yes 2 💆 No Specify: 3 ÎX Widowed 4 □ Divorced Year or Dates:			Specify: W	hite
2-003b	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done	rorking	16b. H	Kind of Business/I	ndustry
7	filed within Hygiene.	ldw	Elementary/Secondary (0-12) College (1-4or 5+) 8 O Homemaker		Ow	n Home	
2	be filed value Hygide of the second of the s	a a		ame (First, Midd	lle, Maidei	n Surname)	
<u>la</u> l	e d ta	To B	boseph w. bccz	e B. Mi			
Maryland 2	s 1 and 2 should by Health and Men Item 27 is marker other traumatic	8	19a. Informant's Name/Relationship (<i>Type. Print</i>) Nancy M. Henderson / Niece 12 North Jerome Park				
	1 and Health em 27	1	Nancy M. Henderson / Niece 12 North Jerome Park 20a. Method of Disposition (Name of cemetery, crematory or other place)	Date Date		ocation - City or	
ē	Pages nent of int: If Its iry or o		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Gds. 10	/31/2009	Syk	esville,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or ottoe.		21. Ignatur of Funeral Service Licensee 22. Name and Address of Facility F				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			ie, rary.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Cause on each line.				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Examiliei	ē.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				_
	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	
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68760,	ficate the physical p	edical	d				
Box (eath certific attending p for use as t	m/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of de	
O. B	at the deat by the atta tached for	Physician/M	in the past 12 months? 1		-	Month	Day Year
<u>~</u>	that the ed by detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Di	id tobacco	use contribute to	the cause of death?
rds	quires that in signed l	ed by		1[Yes	2 No 3 □ P	robably 4 Unknown
ec0	e law require has been sig je 2 should b	Completed		24a. W	topsy	prior to	utopsy findings available completion of cause of
<u> </u>	Physician: The la r this certificate har ral director, page 2	Com		1 □ Ye	erformed?		2 □No
Ĭ	sician certifi rector	Be	examiner?	Death (Check on		6 □Other (Spe	acifu)
o	ding Phy. h. After this funeral di	n:To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ury occurred	iony)
ö	ending F eath. or: After he funer	atio	2 Accident investigation M 1 Yes 2 No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street a Town, Sta		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier (Check only (Ch	ace, and due to	the cause	e(s) and manner a	s stated. e to the cause(s)
	the H thin 24 the Fi	Medical	one) and manner stated. 29b. Signature and title of certifier. 29c. License number			Date signed (Mon	
	7 × 6 ⊗		296. Signature and the of certifier MS MD D50108			11/3/	2009
	121		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	100		Michael Downing 7845 Oakwood Road Who Burne W	OIS an	61		
	Sta Regist	ate rar	31. Date filed (Morth, Day, Searning) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

09-08478 John Hare Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

onn naie	1- For State Certificate of Deat	th	g. No. 2009 3556
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) John E. Hare, Jr.	2. Date of Deat Month November	3. Time of Death
	4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death	4c. County of Death N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	ler 1 Year If Under 24Hrs. 8. Date of Birl	h(MM/DD/YYYY) 9. Birthplace (State or
Director	213–11–1061 XX _{M 2} F 24 Yrs. Montt	ns Days Hours Min. Aug 4,	1985 Foreign Country) MD
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
or 28a-f show fied at once,	Md N/A Baltimore		1 XXYes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once.		21211	U.S.A.
hours after death with the Maryland natural", or items 23a or 28a-f sto Examiner must be notified at once.	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Armed Forces? 1 Yes 2 XX No	ent of Hispanic Origin? (Specify Yes or No- ify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
rs after of mral", of miner n	3 Wildowed 4 Divorced or Dates:	No specify: Occupation (Give kind of work done	Specify: White 16b. Kind of Business/Industry
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Pth College (1-4 or 5+) College (1-4 or 5+)	orking life. DO NOT use retired) Ce Electrician	IBW Local 24
5-003 ed withii tygiene. other th h. Med	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, N	
2121! ould be fil d Mental F s marked tic event, To Be	John E. Hare, Sr.	ny nber, City or Town, State, Zip Code)	
MD 2 od 2 shoulth and 1 m 27 is r	Joanne Hare (Mother) 1327 West	t 40th Street Balto	, MD 21211
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati injury or other traumatic event, the Medical Exa	20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Na Duraney Valle)		20c. Location - City or Town, State Timonium, MD
Saltin ermit. P. epartmei nportan ijury or	4 Donation 5 Other Specify: 21. Signature of Fungral Styles decrease 22. Name and Burgee.	d Address of Facility - Henss-Seitz Funeral	Home Inc
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	alls Road Balto. M	21211 est, shock, or heart Approximate Interval
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Combined druss (methadon or condition resulting in death) Due to (or as a consequence of): Intoxical	e, diazepam, alprazo	Death Between Onset and Death
	Sequentially list conditions.		
usit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last events resulting in death). Last Due to (or as a consequence of): Due to (or as a consequence of):		
ecuted and transit	events resulting in death) Last Due to (or as a consequence or):		
60, ate be ex hysician e burial	d. AMENDED 23a, 27, 28a-f, permE IF FEMALE: 23c. If yes, outcome of pregnancy	, g897 11/13/09 TT	23d. Date of delivery
tox 68760, each certificate be executed attending physician and for use as the burial - transit.	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spi		Month Day Year
D.O. Box 687 that the death certific red by the attending a detached for use as tl by Physician/	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlyin		obacco use contribute to the cause of death?
P.C es that igned oe dets			s 2 No 3 Probably 4 V Unknown
Records, The law requires ficate has been sig , page 2 should be Completed		24a. Was autoperfo	
of Vital Recing Physician: The After this certificate Inneral director, page on: To Be Com		1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
F Vital Physician r this certi	1 Ves 2 No Inpatient 2 ER/Outpatient 3		Residence 6 Other:
on of ending Pl ath or: After the funera	27. Manner of Death 1	28c. Injury at Work? 28d. Describe 28d. Desc	how injury occurred
	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) Found: residence	or Town, S	Street and Number or Rural Route Number, City State) 1327 W. 40th St
		ne time, date and place, and due to the cause	se(s) and manner as stated.
To the H within 24 To the F complete	one) 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated. 29b. Signature and title of certifier	ny opinion, death occurred at the time, date	and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	my in. vs	O.C.M.E.	November 2, 2009
oxpend	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Balt	timore, MD 21201	
State	31. Date filed (Month, Day, Year) 32. Fegistrar's Signature	0	
DHMH 17 Rev 1/2001	ORIGINAL	y	OCEAE

09-08456 Ashton Hunter

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ionion nomo		- For State Certification - Ce	tificate of			. No.	00 255		
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)			2. Date of Death Month October 31	Day Year 2009	2051 hrs		
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4	b. City, Town, or Location of Cheverly		4c. County of Death Prince George	's		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la	10	If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth Min. 11/12/	(MM/DD/YYYY) 9. Birth 1989 Foreig			
w any		Usual Residence of Decedent	Town or Location	on	11/12/	1303	10d. Inside City Limits		
	tor	DC WAS	SHINGTO	ON 10f. Zip Code	10	g. Citizen of What Cour			
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	al Director	318 37th ST., S.E. #304	S 13 Was	20019 s Decedent of Hispanic Origin	n? (Specify Yes or No-	UNITED S	TATES		
fter d	by Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced of Dates:	If Y∈	es, specify Cuban, Mexican, Yes 2 No specify:	Puerto Rican, etc.)	White, etc. $\begin{array}{c} \text{White, etc.} \\ \text{Specify:} \end{array}$	ACK		
, MD 21215-0036 and 2 should be filed within 72 hours a fealth and Mental Hygiene. tem 27 is marked other than "natura traumatic event, the Medical Examin traumatic event, the Medical Examin	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	is Usual Occupation (Give kost of working life. DO NOT i ${ m STUDENT}$		16b. Kind of Business/I			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Comp	12th 17. Father's Name (First, Middle, Last) CLAYTON DADDNEY	aiden Surname)	ON					
MD 2121 on 2 should be fill alth and Mental I am 27 is marked sumatic event,	10 B	19a. Informant's Name/Relationship (Type, Print) ELAINE HUNTER/MOTHER	1	Address (Street and Num 7th St., N		per, City or Town, State	e, Zip Code) 0 0 1		
Baltimore, ML permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Quonation 5 Other Specify:	Place of Disposi crematory or oth	ition (Name of cemetery, ner place) ET CEM.	Date 11/11/09	20c. Location - City or WASHING			
		21. Surfature of Funeral S. Noce Licensee	lu 1.	lame and Address of Facility 4 2 5 MARYLAN ne mode of dying, such as G	ND AVE., N	NE WASH.,	DC 20002 Approximate Interval		
Physician /Medical *xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do no enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final sease or condition resulting in death) Due to (or as a consequence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Detection of the Company of the C							
760, cate be executed physician and the burial - transit	cal Exa	events resulting in death) Last d. UNPENDED AMENDED							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi									
P.O. Bes that the digned by the	Ď	Part II. Other significant conditions contributing to death but not r	esulting in the u	underlying cause given in Pa		bacco use contribute to	o the cause of death?		
Division of Vital Records, P.O. Box 687 rate attending Physician: The law requires that the death certifi rs after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the control of	Completed				24a. Was autop perfo 1 V Yes	sy prior to death?			
ician: Ti certifica rector, pa	Be Co	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ED/Outpatien	26.Place of Death		Residence 6 Oth	er:		
	tion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Pending	28b. Time of FOUND: 2006 hrs		? 28d. Describe	now injury occurred			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify). 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Ci or Town, State) 342 37th Street, SE, Washington, DC							
	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	dge, death occu and/or investiga	ation, in my opinion, death o	ocurred at the time, date	and place, and due to	the cause(s)		
	ž	29b Signature and title of certifier Color Valle Jekk	80	O.C.M.E.		29d. Date signed (November 1, 2)			
		30. Name and address of person who completed cause of death (Iter Victor Weedn MD JD Assistant Medical Exami		Penn Street, Baltimor	re, MD 21201				
S Regis	tate trar	~ 5 0000 8	d. ba	Kal					
DUMH 17 Box 1/2	224	NUT	OPICINI						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2009 35565 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 10:45 A M Jane Hennegan November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville College Manor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 2 🗓 F Maryland 216-24-9755 81 December 12, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exeminating the Inciting at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County New 1 □Yes 2 No Director Cherry Hill Camden Jersey 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 08003 1970 N. Birchwood Park Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Mae Fischer Eselhorst, Sr. Albert Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1524 Norman Avenue, Lutherville, Maryland Joseph E. Hennegan/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/3/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road, Towson, Maryland used the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No-1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manne r stated License number 29b. Signature and title of certifier

State Registrar 30. Name and address of person who comp

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 200 Harri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Genesis Nursing Home 8. Date of Birth (Month, Day, 10/29/ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) _____ 7. Age (In yrs. last birthday, 6 Sex 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🔀 F T.A 434-60-4013 67 Yrs. 1942 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evan ingrant ust be notified at ¥ Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21225 2406 Seabury Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces 1 ☐ Yes 2 If Yes, Give 2**7** No 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Completed by 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Lacoste Harris Sr. Harris Oscar ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Heathfield Rd. Baltimore, MD 21239 Dalton L. Journee Jr. 1642 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Final Journey Crematory 11/5/2009 Woodbine, MD 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Borota Marshall, "Mouston 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nephropa **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐ Yes 2 No 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2X No 28d. Describe how injury occurred

Box 68760, P.0. Hospital or Attending Physician: The law requires that Division of Vital Records, filled in by the funeral director, Certification: To After this after death. within 24 hours a

To the Funeral

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2☐ Medical Ex 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

evA,

State Registrar

completely

the

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RLes G. 0 Voven /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yrs. Director 78 Jan 31, 1931 Maryland 219-40-6085 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number by Funeral 432 Shirley Manor Road 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😿 No Specify: Specify: 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other trainmeth. Elementary/Secondary (0-12) College (1-4or 5+) 07 n/a Laborer/Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Lisbon M. Jackson Anna Cheatham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 432 Shirley Manor Road, Reisterstown, MD Rebecca Jackson/Wife 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/7/09 Timonium, Maryland Dulaney Valley Memorial Gardens 21. Signature of Fundral Visice to his Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part f. Enter the disease, or complications that shock, or hear failure. List only of e cause on Approximate Interval Between Onset and Death Immediat Cause Final disease or Fillion resulting in death) **Physician** heros 200 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last physician ars the burial-tr Due to (or as a consequence of) Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 2 🗆 No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26 Place of Death (Check only one) Other: 4 □ Nursing Home 5 □ Residence 62 Other (Specify) Be Hospital: ဥ 1 Tes 3 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day, Year) 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

WXI

altimore, Maryland 21215-0036

O: Box 68760,

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of Vital Records,

Division

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIRMO

32. Redistrac's Signature

29c. License number

29d. Date signed (Month, Day, Year)

■ Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760,

		For State Registrar	Cer	rtificate of	Death		Reg. No.2 1 1 C	35568	
Physici /Medic		Decedent's Name (First, Middle, Last) Clement	tine Jacks	on		2. Date of Dea Month	th Day Year	3. Time of Death 2:52a M	
Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De		
		Future CareLochern (nee Vill 5. Social Security Number 6. Sex 7. Agr	a St. Michael) e (In yrs. last birthday)	If Under 1 Year	Baltime	ore 8. Date of Birth		I/A irthplace (State or Foreign	
or 28a-f show or notified at	To Be Completed by Funeral Director	214-28-2946 Usual Residence of Decedent	78 Yrs.	Months Days	Hours Min.	(Month, Day Sep 21,	, Year) (Country) Maryland	
		10a. State 10b. County Maryland N/A	10c. City, Town or Lo		timore			10d. Inside City Limits X☐Yes 2☐No	
		10e. Street and Number		10f. Zip Code	04045		10g. Citizen of What 0	•	
eath v		3517 Hayward Avenue 11. Marital Status 12. Was Decedent I	Ever in IIS 13 V	Was Decedent of H	21215		nerican Indian,		
be filed within 72 hours after death with the Maryland tall Hygiene. Adother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced Armed Forces? 1 Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 24☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh Specify:		
		15. Decedent's Education (Specify only highest grade completed)	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				6b. Kind of Business/Industry	
d with giene. er thar		Elementary/Secondary (0-12) College (1-4or 5	Homemaker				Own	Own Home	
e d stal		17. Father's Name (First, Middle, Last) Emerson Jackson		18. Mother's Name			e (First, Middle, Maiden Surname) Francis Jackson		
		19a. Informant's Name/Relationship (Type. Print) Kenneth Jackson		-			r, City or Town, State Maryland 21215		
00		20a. Method of Disposition 10 Burial 2 Cremation 3 Removal from State	1	matory or other pla	· i a	2009 4/09/09	20c. Location - City o		
permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee		armel Cemet 2. Name and Addre Estep Bro	es of Facility				
4.2		23a. Part. Inter the disease, or complications that caused	the death. Do not ent	1300 Eu	others Funera taw Place Ball	timore, Md	21217 rest	Approximate	
Physician		23a. Part : Enter the disease, or complications that caused the death / Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a							
/Medical Êxaminer	L	Due to (or as	a consequence of):	Left	lower	- Ext	enrity	6 months	
oe executed cian and ourial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a confequence of): Find stage Renal & seare on 13;						
tificate be exe g physician a		Due to (or as a consequence o): d. Tail UTE to thrive						6 months	
leath certificate be attending physici	/Med	IF FEMALE: 23c If was outcome	of pregnancy				T		
	o Be Completed by Physician/Medical	in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				23d. Date of o	23d. Date of delivery Month Day Year	
uires that the signed by the		Part II. Other significant conditions contributing to death be	ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact 1 ☐ Yes					acco use contribute to the cause of death? s 2 1 10 70 3 Probably 4 Unknown	
he law requires t e has been signe age 2 should be o						24a. Was autop	sy prior t	autopsy findings available o completion of cause of	
slcian: The law certificate has l irector, page 2 s		05 W(s) (s) (s) (s)				1□ Yes	rmed? death 2. No 1 ☐ Y		
slcian: T s certificate irector, pa		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩6 Hospital: 1 ☐ Inpatie	<i>ne)</i> ience 6 □Other (Si	Daniful					
ding Phys h. After this funeral dii	ion: To	27. Manner of Death 1 Matural 5 □ Pending (Month, Da	now injury occurred	Decily)					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, f.	Certification:	2 Accident investigation 3 Suicide 4 Homicide M 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Stree Cify or Town, S						et and Number or Rural Route Number, State)	
	Medical Cer	29a. Certifier (Check pnly Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the I		and manner stated.						d. Date signed (Month, Day, Year)	
		30. Name and address of person who completed cause of d	6 CAN	D00	59014		11/2	109	
		31. Date filed (Month, Day, Year)	eath (Item 23a) (Type, 2600) ar's Signature	LIBER	TY HE	Elatt	SAVE	sight and	
Sta Registi		MOV OK 2009	A. Aa	wed .	-				
- C	001	MALA A PARA YELLAND							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar	zr rran y tarre	Cer	tificate of L	Death	Re	g. No. 200	9 35569
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Ruth Je	nkins			2. Date of Death Month	Dav _ Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and nur		IIKIIIS		Location of Death	Novem)	4c. County of Dea	ith
, d'	Company		Union Memoria 5. Social Security Number 6. Sex	al Hospital 7. Age (In yrs. las	st hirthday)	If Under 1 Year	Baltin	NOTE 8. Date of Birth	1	N/A rthplace (State or Foreign
	Funeral Director		213-34-8936 1 M 2 X F	76	Yrs.	Months Days	Hours Min.	Month, Day, Mar 3,	1933 °G	Wash., D.C.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. once.	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits	
	e Mary r 28a-f notifie	Funeral Director	Maryland n/a 10e, Street and Number				altimore			1 Yes 2 No
	s 23a o		2306 Ruskin Avenue			10f. Zip Code	21217	10	og. Citizen of What Co	S.A.
	urs after deatt ural", or item il Examiner m	þ	Armed Fo	2 💢 No ve		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	sify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
15-(72 hou In "nat Medica	Be Completed	15. Decedent's Education (Specify only highest grade completed		(Give I	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of workin	g	6b. Kind of Business	ŕ
212	d within ygiene. her tha ht, the I		Elementary/Seconday (0-12) College (1	-4 or 5+)			are Provider			ivate
and	be filed lental H rked ot tic ever	To B	17. Father's Name (First, Middle, Last) Henry Robinson				18. Mother's Name		aiden Surname) e Robinson	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Menta Hygiene. Important: If item 27 is marked other than "natural", on any injuny or other traumatic event, the Medical Exam	nd 2 should ealth and N n 27 is ma		19a. Informant's Name/Relationship (<i>Type, Print</i>) Yolanda Jenkins				and Number or Rural venue Baltimo		City or Town, State, Zi	p Code)
timore	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State cer	metery, cren	sition (Name of natory or other plac prest Veteran	e)	ate 2 11/10/09	Oc. Location - City or	r Town, State Mills, Md.
Ba	permit Depar Impor any in		21. Signature d'uneral Service Licen	16	22	Name and Address Estep E	ss of Facility Brothers Funer utaw Place Ba	al Service, f	P. A.	
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ea	caused the death. ach line.	Do not ente	er the mode of dying	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between
F	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Consequence of: Due to (only a consequence of):							
	Examiner	١	S Fr	id Sto	Sp	Rena	Dise	case		
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linitury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertensive Due to (or as a consequence of):							
	tificate be executed ng physician and as the burial-transit	al Exa								
68760	tificate b ng physic as the b	Medical	d						1	
. Box 68	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. Within 24 hours after death. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Completed by Physician/N	in the past 12 months?	tcome of pregnand Birth 2 Fetal of gnant at time of de nown	death 3 [Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year
ds, P.O.	quires that t en signed b suld be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Records,	The law recate has be page 2 sho							24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
ta Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital:	Inpatient 2 XE	-B/Outpatier	Otho	er:		ice 6 🗆 Other (Spec	0.164)
Division of Vital	ath. r: After thi ne funeral	Certificate: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work	at 2	8d. Describe how	_	<i>ay)</i>
Divisi	tal or Affer sa affer de al Directo ed in by the	Medical Certif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)				t, factory, office 28f. Location (Street a City or Town, Stat			ral Route Number,
	the Hospi hin 24 hou the Funer npleted fill		29a. Certifier (Check only one) 1	sis of examination a	and/or invest	tigation, in my opinic death occurred at the	n, death occurred at t e time, date and place	he time, date and , and due to the c	place, and due to the ause(s) and manner as	cause(s) and manner stated. s stated.
	or Vit		29b. Signature and Mile Wife Certifier			29c. License	5545°	7 29	d. Date signed (Mont	3, 2009
			30. Name and address of person who completed cause	se of death (Item 2	23a) (Type, P	MD Un	DON Mex	nexia)	Horon	a)
ļ	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 5 2009 32. F	Redistrar's Signatur	A. 14	barker			., .,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle, Last) James F. Kleeman, Sr. Month Physician/ P November 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral X**X M 2 □ F Days Hours (Month, Day, Year, Months 217-24-8521 81 **Director** 17, 1928 MD. Usual Residence of Deceden ems 23a or 28a-f show must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director MD N/A Baltimore 1**XX**Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 811 Funeral 3838 Roland Avenue 21211 U.S.A. 1 and 2 should be filed within 72 hours after death w for Heath and Mental Hyggene.
if item 27 is marked other than "natural", or items, if item 27 is marked other than "natural", or items; other traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Force Black, White, 1 Never Married 2 Married 1 ☐ Yes 2 🗓 💢 🐧 of If Yes, Give White ò Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Monumental Life 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Kleeman Catherine Morrison permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce Kleeman (Son) 1421 Armacost Road Parkton, MD 21120 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 11/10/09 Balto, MD 22. Name and Address of Facility Burgee-Henss-Seitz F 3631 Falls Road Bal 21. Signature of Fureral 5 Funeral hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Metastar) C Ph, sician UNCCUTEM minnon nionth disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 FEMALE 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 🗌 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLUE 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Scortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Moston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 3557 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:15 AMM November 2009 LoPinto Salvatore Frank /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 5504 Edson Lane Rockville 8. Date of Birth (Month, Day, Yea April 22, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Year) **Funeral** Months Country) New York Days Hours 1**X** M 2□ F 1925 84 Yrs 082-18-2101 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County and 2 should be filed within 72 hours after death with the Marylan teath and Mental Hygiene. Az 75 is marked other than "natural", or items 23a or 28a-f show met raumatic event, it is fivelical Examinant must be notified as 1 ☐ Yes 24 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 5504 Edson Lane Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 1943
If Yes, Give 1046 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: White 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunication Buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Vilardi Frank loPinto 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 5504 Edson La., Rockville, MD 20852 Marie LoPinto (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-7-09 Pinelawn, NY Pinelawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature J Funeral Service Licensee 22. Name and Address of Facility Rocky Point Funeral Home 603 Route 25A, Rocky Point, NY 11778 Approximate Interval Between Onset and Death 28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BRAIN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute Exami and the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending I IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ⊒Yes 2□No ed by the a 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by FRONTOTEMPORAL DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an certificate has b irector, page 2 sh autopsy DIABETES MELLITUS TYPE II 1 □Yes 2X No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 5 Pending investigation 1 🕅 Natural after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de Funeral Directo letely filled in by th determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Signature

29c. License number

#33255

29d. Date signed (Month, Day, Year)

NOVEMBER 3, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryfand verge at the of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0510 Eleanor V. Leutert 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) addec r q If Under sumbe 8. Date of Birth (Month, Day, (State or Foreign 5. Social Security Number Hours Min. 1 □ M 2 💢 F 86 13, 1922 Dec Maryland 218-12-5339 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Wiley Ford 1 ☐ Yes 27 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number PO. Box 395 26767 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Warren Luther Squires Rose Virginia Sweitzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sacred Heart Hospital 900 Seton Drive Cumberland, MD 21502 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐Other (Specify) 21. Signature Juneral Signature Ona III State Anatomy Board 655 W. Baltimore Street Baltimore, $_{\rm MD}$ 21201 23a, Pan 1, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

WV

Director

Completed by Funeral

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examine must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner

physician and is the burial-tran attending p for use as 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2

Be Completed

Medical Certification: To

(Check only

31. Date filed (Man)

29b. Signature and title of certifier

Qamar Ul Zaman

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Immediate Suse (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	INFARCTION	Onset and Death
Securations life and life any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		
that initiated events resulting in death) Last	C. Due to (or as a consequence of): d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	livery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
		autopsy prior to performed? death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?		h (Check only one)	
1 Yes 2 No		ome 5 Residence 6 Other (Spe	ecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 1	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ural Route Number,	
29a. Certifier 1 ☐ Certifying Ph	vsician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause(s) and manner a	is stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

21502

29d. Date signed (Month, Day, Year)

State Registrar

BARL

#203 Cumberland,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904 seton Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

t Lesser		State of Maryland / Department of F	Health and Mental Hi Death	Reg. No.	2009 355
Physicia dical Exami	ın/	.)(4)[]	ESSER	Date of Death Month Day November 2, 26	009 Year 2238 hrs
		4a. Facility Name (if not institution, give street and number) 4b.	. City, Town, or Location of Death Randallstown	E	:. County of Death Baltimore County
Funeral Director			Months Days Hours Mir	_	/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
w any	F	Usual Residence of Decedent 10a. State	LTIMORE		10d. Inside City Limits 1 Yes 2 X No
Maryland r 28a-f sho ed at once.	Director		10f. Zip Code 21208	10g. Ci	tizen of What Country? USA
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at ouce.	Funeral	11. Marital Status 1 Never Married 2 X Married 1 Yes 2 No 1 Widowed 4 Divorced If Yes, Give Year	Decedent of Hispanic Origin? (Sis, specify Cuban, Mexican, Puert Yes 2 No specify:	o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", natic event, the Medical Examiner.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	's Usual Occupation (Give kind o ost of working life. DO NOT use re OPTOMETRIST	etired)	. Kind of Business/Industry OPTOMETRY
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	HENRY LESSER	18.Mother's Nar ESTA Address (Street and Number of		E MALMAN
and 2 should lealth and Me tem 27 is ma traumatic ev	2	LESLEY E. LESSER / WIFE 3427	JANELLEN DRIVE	, BALTIMOR	E , MD 21208 c. Location - City or Town, State
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat		1 X Burial 2 Cremation 3 Removal from State BETH TFIL 4 Donation 5 Other Specify:	Jame and Address of Facility	/04/2009 SOL LEVINS	BALTIMORE, MD ON & BROS., INC.
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	8900 REISTERSTO he mode of dying, such as cardia	C or respiratory arrest,	Shock, or heart Approximate Interval Between Onset and Death
'Medica amine	1	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Dis	ease		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibited (Disease or injury			
0, be executed sician and sician and burial - transit	edical Exa	events resulting in death) Last d. UNPENDED X AMENDED PII per ME g8	97 11/10/09 TT		
876 tificate ng phy	Nu Su	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Female 4 Pregnant at time of death 5 0	etal death 3 Ectopic pro		23d. Date of delivery Month Day Year
O. Be hat the de ed by the	Dhy	Part II. Other significant conditions contributing to death but not resulting in the Hypercholesterolemia	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknow
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attend	Z should be	EOO OO		24a. Was an autopsy perform	prior to completion of cause of death?
I Re n: The rtificate	or, page	25. Was case referred to medical	26.Place of Death (Chart		esidence 6 Other:
of Vita ing Physicia After this ce	funeral direct	examiner/ Hospital: 1 Inpatient 2 Rivoutpatient	100	28d. Describe ho	esidence 6 Other:
Division at or Attend s after death	ed in by the	The strict of th		or Town, Sta	
the Hospital	pletely fill		curred at the time, date and place gation, in my opinion, death occu	e, and due to the cause rred at the time, date a	
To the within To the	шоэ	29h Signature and title of certifier 29h Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 3, 2009
		Alctol Meedil MD ap Aggistant meeting	l Penn Street, Baltimore,	MD 21201	
-Da		ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	0 B		
DHMH 17 Rev	g istr v 1/20	MON O 2000 CANOCA JA. CODIGIN	NAL		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2009 William L. Langley 7:40 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year
May 18, 1 Social Security Number 7. Age (In yrs. last birthday **Funeral** Months 1 X M 2 - F 218-01-1817 93 **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State with the Maryland Directo 1 🗆 Yes 2 🗓 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21286 204 E. Joppa Road, Apt. 501 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 Yes 2 X No White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Insurance Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jennie G. McDonough Morgan J. Langley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 204 E. Joppa Road, Apt. 501, Towson, Maryland Marie M. Langley / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holy Rosary Cemetery 11/6/2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Funeral Service Licenses 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition COMPLICATIONS -Pnysician CLIS Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Que to (or as a consequence of): Physician/Medical Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?

Physician: The law requires that the death certificate be |A|M| Will |AM| Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the a funeral director, page 2 should be detached t within 24 hours after death.

To the Funeral Director: After of the funeral pirector of the funeral completed filled in by the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled in the funeral completed filled fill

performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗆 No

Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation

2 🗆 No

1 🗌 Yes

3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, July Ville 29c. License number 29b. Signature a 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 6701 TOWNSON

Registrar

31. Date filed (Month, Day, Year)

1 🗌 Yes

27. Manner of Death

Natural

Accident

6 Could not be

မှ

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9905 7-6-10 yt
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Reg. No U Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month October 30, 2009 6:15 AM M James W. McFaul 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore** Timonium Lorien Mays Chapel 8. Date of Birth (Month, Day, Year) May 5, 1936 9. Birthplace (State or Foreign 5. Social Security Number 9539 219-32-3556 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex Months Days Hours Maryland 1 M 2 □ F 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 5610 York Road #106 21212 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status unk Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No white Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) food industry salesperson 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Viola Appel John Edward McFaul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5904 Sandy Ridge Elkridge, MD 21076 Tracy McFaul/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 ☐ Other (Specify) 21. Sign fure of Ronal Senire Licenses (Conal Co State Anatomy Board 655 W. Baltimore Street Mirector 21201 Baltimore, MD 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS veek. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 1 Tyes 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Onknown BIPOLAR DISORDER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and attending physician the for use as detached ģ signed by page 2 should is certificate has director, page 2 this After this funeral c within 24 hours area Constitution 24 hours area To the Funeral Director: Aff the

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

29a. Certifier

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. CAARLES

GAN-CARDEN , MD

32. Registrar's Signature 31. Date filed (Month, Day, Year)

2

1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7 per Fh g897 11/6/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 C 35576 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lucia Antoinette Marrocco November 2009 7:04 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3905 Eland Road Phoenix Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M XX F Months Days Hours Min. 214-14-4372 86 Director May 22. 1923 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must by rediffed at 10d. Inside City Limits Director 1 ☐ Yes 🗶 📉 No MD Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Eland Road 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic even." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Seamtress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Mason 2 Jennv (Not Known) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3907 Eland Road Phoenix, Maryland 21131 Nicholas Marrocco / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place)
4 Donation 5 Cher (Specify) Entombment Dulaney Valley Mem. Timonium, Maryland 11/4/2009 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Z HEIMMER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequential of) attending physician and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) per 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. ed by t detach signed b Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag To the Hospital within 24 hours a To the Funeral L

72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

LEORLE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 EAST POINT mally 303 BALTIMORE

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	arylan		artment of F rtificate of L		and M	lental Hy	gien Reg. N		9	35577
	Physicia	n/	Decedent's Name		,						2. Date of De	eath		Year 09	3. Time of Death
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Polvell Division of	s after de I Directo d in by th	Certificate:	3 Suicide 4 Homicide	6 L Could no determin		ry - At ho . (Specify)	me, farm, sti	reet, factory, office		7	28f. Location (City or To			or Rural	Route Number,
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611			30. Name and addr	EZ li	o completed cause of de	eath (Item	23a) (Type,	Print) FUT	Dev	SF	Bai	MA	OK O	No	02/201
1	Stat Registra		31. Date filed (Mont	_	32. Regiona	r's Signat	ure A.	pare							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Year Charles E. Parker 6:00 P /Medical November 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Catonsville Baltimore Frederick Villa Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours **X**X M 2□ F 212-36-2169 Director 74 Feb 20. 1935 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment must be notified at Director MD Baltimore 1 □Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 711 Academy Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$\text{Yes}\text{No} \text{If Yes, Give}\text{Year or Dates:} Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ğ Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If item 27 is marked other tha any finiury or other traumatic event, I'm 1 and prie. Clerk Social Security unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Jesse E. Parker Theresa McGowan ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Weiss (Nephew) 1193 Wynterhall Lane Dunwood, GA 30338 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Atlantic Crematory 11/03/09 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Furgee-Henss-Seit 3631 Falls Road Balto, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Officenown page 2 should Completed has been Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA AUNursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation after death Director: 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I ical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Taymou Milli MO D4768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaymons Million smur 25 21134 no 31-Date filed (Month, Day, Year) 32. Register's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Charles L. Richardson 2009 October 26, 8:31 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 28, 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F 1949 60 228-66-0285 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinat must by it tilled at ury or other traumatic event, I'm Medical Examinat must by it tilled at 1 ☐Yes 2√ No Director Prince George's Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4816 Emo Street 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 healthcare cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Lee Miller Norman Richardson ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvira Williams/sister 2013 Chadwick Terrace Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 🖾Other (Specify) in state 21. Signature ... a neral Nona III 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade Vixector Baltimore, MD 21201 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, pr heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aceila Vento cular minilo **Physician** /Medical Due to (or as a consequence of): Examiner vours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Diffuse Hospital or Attending Physician: The law requires that the death certificate be executed Coronon attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by mellitico 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? analouea 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Af
y filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/27/09 024720

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

Koad

32. Regiştrar's Signature

LAVINDER K. RUSTAGI M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	State	of Marylan	-	rtment of F tificate of I		Mental Hy	giene Reg. No.2	009	35580
			Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Time of Death
	Physicia		EUGENE !	TAMES	ROI	13			Month 10	Day 29	2009	SAM
	/Medic Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	
Je s				bilitati	on Exte	ended o	ise	Baltin	nore			(8) 4 - 5 - 1 - 1
	Funeral			6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct 3,	h y, Year) 1021	9. Birthp Coun Mary	place (State or Foreign htry)
	Director		213-16-3186 Usual Residence of Decedent		00	110.			0000	1921	mary.	Tallu
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh	ģ	MD]	Baltimo	re					1 Y Yes 2 □ No
	or 28;	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Coun	ntry?
	23a ust b	ral	287 S. Spring	Court			2123			USA		
	tems	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14.	Race - Americ Black, White,	
36	s afte	by F	1 A Never Married 2 Marrie 3 Widowed 4 Divorced	lf Yes, (Year or		-45	1 □Yes 2🌠 No	Specify:		Sp	pecify: whi	te
ခု	tural	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	oation		16b. Kind	of Business/Inc	dustry
2 2	a. In "na	plei	(Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give life. i	kind of work done of DO NOT use retired	during most of worl d)	king			
2	d with	Completed	12	0		t	ool inspe					
2	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show matic event, the Maritical Eventines into the intifficial	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	ne (First, Middle) Line Pet		rname)	
<u> </u>	should be tand Mental s marked o	٩	Eugene Roda			101 14 75	A 11 (Ct				own State 70	- Cadal
Maryland 21215-0036	12 sh th and 7 is n traun		19a. Informant's Name/Relationsh Rosalee Ray/cot			1	ng Address <i>(Street</i> NW 47th S					
	es 1 and 2 should b of Health and Ment fitem 27 is markec r other traumatic e		20a. Method of Disposition	19.111	20b. I		sition (Name of natory or other place		Date		tion - City or To	
Baltimore,	Pages nent of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	Removal from	n State	cemetery, crei	natory or other plac	ce)				
Balt	permit. Page Department of Important: If any injury or once.		21. Signa ure of Euneral Sarvice L Rona	ice see	Directo	r 22	State An	es of Facility Boa e, MD 21		W. Ba	1timore	e Street
			23a. Part 1. Enter the disease, or o	complications that	t caused the deal	th. Do not ent				rrest,		Approximate Interval Between
	Physician	8	shock, or heart failure. List of			RCINE	MA S	SARIL	CFIL			Onset and Death
	/Medical		disease or condition resulting in death)		o (or as a consec		- /	1412				
	Examiner	L	Sequentially list conditions.	b								
	ed sit	ine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a consec	(uence of):						
	xecut and	Examiner	that initiated events resulting in death) Last	c Due t	o (or as a consec	uence of):						
8760,	icate be executed physician and the burial-transit	dical E	(d								
687	ifficate g phy as the	edic	<u> </u>	U			46.					
Вох	eath certific attending p	N/u	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		☐ Ectopic pregnanc	CV.		230	d. Date of deliv	
о. В	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No		egnant at time of		Other (specify)				Month	Day Year
ď	at the ded by the seletached	Phy	9 ☐ Unknown Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ds,	iires that signed k d be deta	l by	0:	truc TTVE	//:	noncy	Disea.		1 🗆	Yes 2□	No 3 Pro	bably 4 ☐ Unknown
Ö	w requir s been si should I	etec	Hugochesis						24a. Was	an	24b. Were aut	opsy findings available
Record	he lav e has ige 2	Completed by	11914 14120	~						psy ormed?	prior to co death?	ompletion of cause of
	an: T tificat or, pa		25. Was case referred to medical	1				26. Place of Dea	1 ∐ Yes ath (Check only	2 2 No	1 □Yes	2 🗆 140
<u> </u>	Physician: The lav this certificate has al director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2] ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing H	Home 5 ☐ Res	idence 6 [☐Other (Spec	ify)
0 0	ng Ph fter th neral	L H	27. Manner of Death X Natural 5 ☐ Pending	/1.4	te of Injury onth, Day, Year)	28b. Time o	Wor	rk?	28d. Describe	how injury o	occurred	
<u>S</u>	eath. or: A the fu	catio	Accident investig 3 ☐ Suicide 6 ☐ Could n	ation]Yes 2□No	001 1	(a) (N	- I Davida Musebar
Division of	lor At after d Direct I in by	Certification:	4 ☐ Homicide determi	, 28e. Pla	ice of Injury - At r ilding, etc. <i>(Spe</i> c	ify)	reet, factory, office		City or To	wn, State)	vumber or Hur	ral Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,		(Check only 2 Medical I	Examiner: On the	e basis of examin	owledge, dea	th occurred at the to	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) a , date and p	ind manner as place, and due	stated. to the cause(s)
	thin 2 the l	Medical	one) 29b. Signature and title of certifier	and m	anner stated.		29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
	# 3 # 8		10 /1	1/1/			172	3760	7	On	5/00	79 7.25
			30. Name and address of person of	who completed ca	ause of death (Ite	m 23a) (Type	Print)	/	0.	المات	7	29, 2009 TY 21218
			DEBRAS WE	PHEIL	^	0 .	3900 La	chRave	en Ela	V. B	alto	PHZIZIS
	Sta		31. Date filed (Month, Day, Year)	32	. Registrar's Sign	ature				/		
	Regist	rar	NOV 05	2009		1 1	en led					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Simmons **Physician** Thonso 2009 OH 1:20 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DALTIMORE VA Medical Center | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. | 16, 5. Social Security Number 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F **Director** 263-20-3125 86 Florida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐Yes 2 No Windsor Mill Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō United States 21244 7409 Castlemoore Road items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer General Contracting unknown other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Heges Simmons unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any injury or other trau 706 Linda Drive, Catonsville, Maryland Estel Swayne/ Caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 5, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonic /Medical Due to (or as a consequence of): Examiner nterococcu Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours area To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

2+1

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

10 North Greene Steer BALTIMORE, MD 21201

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

		-	State of Maryland / De State of Maryland / De Registrar	epartment of Health and N Certificate of Death	lental Hygi	ene g. No. 2009	35582
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death
	Physicia Medic	al	Walter C. Stottlemyer Jr		October 0	21, 2009	7:00 PM M
. T.	Examin	er	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g, Birth	place (State or Foreign
	Director		219-40-7304 1 M 2 □ F 66 Yr	s. Months Days Hours Min.	(Month, Day,) Aug 4, 1	943 Mary	land
	nd show at	o.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	r Location			10d. Inside City Limits
	//aryla 8a-f s tified	rect	MD Harford Be	l Air			1 ☐ Yes 2 X No
	a or 2 be no	io le	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	720 Burnside Drive	21015	eitu Vas ar Na	USA	
0	er dea or ite niner	by Ft	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - Amer Black, White	, etc.
8	ırs afte ıral", I Exar	ed b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 161-69	1 ☐ Yes 2 🛣 No Specify:		Specify: Wh	ite
5	2 hou "natu	plet	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of worki	ing 1	6b. Kind of Business I	ndustry
7	ithin itene.	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired) truck driver		transport	ation
ס פע	illed w Il Hygi I othe vent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
ylar	e should be filed v h and Mental Hyg 7 is marked othe traumatic event,	입	Walter Conway Stottlemyer	Dorothy	Mae Wri	tt ———	
Maryland 21215-0036	2 shouth and the and the strain traum			Mailing Address (Street and Number or Rura Burnside Drive Bel		City or Town, State, Zip 21015	Code)
ნ	f Healf f Healf item 2		20a. Method of Disposition 20b. Place of D	isposition (Name of		Oc. Location - City or	Town, State
E C	Page nent or ant: If oury or		4 \(\Dig \) Donation 5 \(\text{Other (Specify)} \)	crematory or other place)			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatu e Fineral Service Liven	State Anatomy Boar Baltimore, MD 212		Baltimore	Street
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure/ List only one cause on each line.			t,	Approximate Interval Between
Ŧ	hysician	l li	The state of the s	RENAL DISEASE			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of) ATHEROSCIE				Arause
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)	K/21/3			DECADES
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.				
	cate be executed physician and the burial-transit	al E	resulting in death) Last Due to (or as a consequence of)				
760	cate b physi s the b	edical	d				
89	certifi anding use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of deli	very
Box 687	death he atte	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	5 Other (specify)		Month	Day Year
P.O.	nat the ed by t detach		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
S,	uires the n signer and be	Completed by	HEPATITIS C		1 Yes	s 2 No 3 Pr	obably 4 🗆 Unknown
Ö	iw requals bee	plet	EMPHYSEMA		24a. Was an autopsy		opsy findings available ompletion of cause of
Rec	The la	Com			perform		2 🗆 No
ta	iciant Sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check			the Dies
∑ <	Phys ir this eral dir	e: 1	27. Manner of Death 28a. Date of injury 28b. Tin	ne of 28c. Injury at	me 5 Resider 28d. Describe hov	nce 6 🔼 Other (Speci v injury occurred	M HOSPICE
ouo	ath. ath. r: Afte	icat	1 № Natural 5 □ Pending (Month, Day, Year) inju	ıry work? M1 □ Yes 2 □ No			
Division of Vital Records,	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or i	nvestigation, in my opinion, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
	o the l	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	dge, death occurred at the time, date and place 29c. License number		ause(s) and manner as a decided. Date signed (Month	
	- > - 0		1 10000/n	164395	0	CTOBER 2	2,2009
			30. Name and address of person who completed cause of death (Item 23a) (Ty				
	-01		31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	A	105 BA	TIMORE, A	10 21204
	Sta Registr		NOV 05 2009 Server S.	parel			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Smith Edmonia J. 10: 35PM October 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** I Shasta Circle Baltimore Apartment D Mills Owings 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2**X** F Months Days Hours 213·34·4090 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination any injury of other traumatic event, the Medical Examination and other any officer and other traumatic event, the Medical Examination and other any officer and other traumatic event, the Medical Examination and other any other traumatic event, the Medical Examination and other any other and other any other and other any other and other any other and other any other and other any other and other any other and other any other and other and other any other and other any other and other any other and other any other and other any other and other any other and other and other any other any other and other any other any other and other any other and other any other any other and other any other and other any other and other any other any other and other any other any other and other any other any other and other any other any other and other any other any other and other any other and other any other any other an 1 □Yes 2 Vo MD Mills Paltimore Director OWINGS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2117 USA Shasta Circle Apartment Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black 5 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) ustodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lara Jones မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Shasta Circle Apartment Dowlings Mills MD Venice D. Washington/Daughter altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State St. Lukes UMC Cametery! 109 Reisterstown, MD 11/06 22. Name and Address of Acility C. Greene Funeral Services C. Road Randaustown MD21133 _8 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to or as a consequence of): weight less Examiner C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner death certificate be executed and burial-tran Box 68760. the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown icate has been si , page 2 should b 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 ☑ No Vital Physician: After this certifications funeral director, p 25. Was case referred of medical Be 26. Place of Death (Check only or-) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-4050 01d

32. Registrar's Signature

29c. License number

Court Renn

29d. Date signed (Month, Day, Year)

10 very beg 2 md, 200 9

09-Ho

-08535 ward Shorr		Please Typ Sta	e or Print in late of Marylan	d / Depart	ment of	Health an	e All Cop d Mental I	ies Are L€ ⊣ygiene	egible	2	009	3558
Physicia	n/ 1	For State egistrar . Decedent's Name (First, Middle	e,Last)	<u>Certif</u>	ficate of			2. Date of De Month November	Reg. No. eath Day		3. Time	of Death
edical Examir		HOWARD a. Facility Name (if not institution	a give street and numb	ner)		SHORR 4b. City, Town, or	Location of Dea		40	. County of E	Death	
	2	Carroll Hospital Center	-	JCI)	i	Westminste				Carroll		
Funeral		. Social Security Number	6. Sex 7.	. Age (In yrs. last	birthday)	If Under 1 Year		rs. 8. Date of E	Birth (MM/	(DD/YYYY) S). Birthplace (oreign	
Director		187-40-1624	1 X M 2 F	59	Yrs		/s Tiours	05-02	<u>- 195</u>	0	Country)	PA
Á	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Loca	tion					10d. ln	side City Limits
low any		MD CARROL	1		ESVILL						1 🔲	Yes 2 X No
death with the Maryland or items 23a or 28a-f show a must be notified at once.	0 L	10e. Street and Number		OTIKE		10f. Zip Code			_	izen of What	Country?	
the Marified		6514 SHENANDOAF	H DRIVE			21784			US			San Dingk
n with	era	11. Marital Status 1 Never Married 2 X M.		dent Ever in U.S. ces?	. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or lerto Rican, etc.)	No-	14. Race - White,	American Indi etc.	lan, Black,
r death or ite	Funeral		orced If Yes, Give Year	2 No	1	Yes 2 X N	o specify:			Specify:	HITE	
irs afte ural",	<u>a</u>	Widowed 4 Div 15. Decedent's Education (Spe	or Dates:	completed) 1	16a. Decede	nt's Usual Occup	ation (Give kind	of work done	16b.	Kind of Busi	ness/Industry	
72 hou n "nat	etec	Elementary/Secondary (0-12)				most of working lif	e. DO NOT use	rearea)	1,,,,			
5-0036 fled within 7 Hygiene. I other than	Completed		2		TECH	NICIAN	18 Mother's N	ame (First, Middl	HV e, Maide			
15-C filed vall Hygi ed oth	Be Co	17. Father's Name (First, Middle JONAH	, Last)	SHO)RR		THELMA	1			SAGET	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death wi Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: injury or other traumatic event, the Medical Examiner must be,	To B	19a. Informant's Name/Relations	ship (Type, Print)	5.110	19b. Maili	ng Address (Str				_		
MD d 2 shc Ith and n 27 is		HOLLY SHORR/WIF	FE	Took D	6514	SHENANE osition (Name of o	OAH DRI	VE SYK	FSVI 200		1D 2178 City or Town,	
ore, slan of Hea If iter		20a. Method of Disposition 1 Burial 2 Crematio	n 3 X Removal fro	Cr	ematory or i	other place)			- 1			1
Baltimore, permit. Pages 1 a Department of He Important: If ite	V g	4 Donation 5 Other S 21. Signature of Funeral Service	Specify:	5001	1H FLU	RIDA VA	CEM. 117	1-05-200	NSUN 0 1 D	& BRC	THERS	INC.
Balti permit. Departn Imports) is	RIT	1	>	1 8	900 REIS	STERSTON	IN ROAD,	PIK	ESVILL	E, MD	21208
Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications that ca	used the death.	Do not ente	the mode of dyin	ig, such as card	iac or respiratory	arrest, s	hock, or hea	rt App Bet	roximate Interval ween Onset and Death
(Medical caminer	i	Immediate Cause (Final disease	e a. Bactere			monia						Death
		or condition resulting in death)	Due to (or as a b.	consequence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Filler Underlying Cause	Due to (or as a	consequence of):							Ì
	ami	(Disease or injury that initiated events resulting in death) Last	Due to (or se a	consequence of):							
executed an and al - transit	al Exa		d									
tox 68760, eath certificate be executed teath certificate be executed to a stending physician and for use as the burial - transit	Physician/Medical	X UNPENDED	AMENDED	23a,27,p	erME	g897 11/	16/09 T	<u>"T</u>		23d. Date of	delivery	
Box 68760, a death certificate be the attending physic of for use as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes,	outcome of pregr pirth	nancy 2	Fetal death	3 Ectopic p	regnancy	- 1	Month	Day	Year
x 61 th cert ttendir	icia	past 12 months?		ant at time of de	ath 5	Other (Specify)			- 1			
. Bc the dea y the a	K	Part II. Other significant cond	3 OIII		esulting in th	e underlying caus	se given in Part					ause of death?
cords, P.O. B aw requires that the d has been signed by the 2 should be detached	\$							1	Yes 2			4 Unknown
rds, require been si	etec		-			_		_	Was an autopsy) ;	orior to compl	findings available etion of cause of
COI re law te has l									performe Yes 2		death?	2 No
Division of Vital Records, tal or Attending Physician: The law requires after death. After this certificate has been sted in by the fineral director, page 2 should the	Be C	25. Was case referred to medi-					lace of Death (C					
Vita hysicia this ce	0	examiner? 1 ✓ Yes 2 No	Hospital:		ER/Outpat		Other ₄ Injury at Work?	Nursing Home		sidence 6	Other:	
n of ding Pl	Ë	27. Manner of Death 1 X Natural 5 Pe	28a. Date (Mont	e of Injury h, Day,Year)	200. 11110	· ' ' _	Yes 2 1					
ivisior or Attend after death Director:	icati	2 Accident In	vestigation 28e Plan	ce of Injury - At h	nome, farm, s	street, factory, offi	ce building, etc.		tion (Stre		er or Rural R	toute Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic from the Purilled in by the funeral director, page 2 should be detached for use as the burit.	alc	20a Cortifier	Physician: To the be xaminer: On the basis	est of my knowled	ige, death o	ccurred at the time	e, date and plac	e, and due to the urred at the time,	e cause(s date and	s) and manne d place, and	er as stated. due to the ca	use(s)
Division of North Hospital or Attending Physicial or Attending Physicial 24 hours after death. The formers Director: After the Commendative filled in by the finental companies to filled in by the finental property of the filled in by the fille	Medical	29b. Signature and title of cert	and manner	stated.	unidi di dives		cense number		2	29d. Date sign	ned (Month,	Day, Year)
	2	29b. Signature and title of cert	1	(M)			.C.M.E.		1	Novembe	r 4, 2009	
		30. Name and address of pers	son who completed car	use of death (Iter	m 23a)							
		Melissa Brassell, M		edical Exami	iner 11	1 Penn Stree	t, Baltimore	, MD 21201				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35586 Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30 2°00 9 4c. County of Death 4b. City, Town, or Location of Death MONTGOMERY OLNEY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 2 3 / 7. Age (In yrs. last birthday) Months Days Hours Min 2X F T927 1 □ M 81 10c. City, Town or Location 10b. County SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code

Physician 2100 M EUGENIA STEVENSON /Medical 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY GENERAL HOSPITAL Birthplace (State or Foreign Country) Social Security Number **Funeral** 114-64-8516 Director LIBERIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ing Modical Examinar must be inclined at 1 ☐Yes 2 ☐ No MD Director 10e. Street and Number LIBERIA 20906 3731 CAPULET TERR Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: BLACK 3√ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREEMAN NANCY WILLIAM WORDSWORTH ဂ္ 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906, MD

GWENDOLYN STEVENSON-THIAM/DAUGHTER 3731 CAPULET TERR. SILVER SPRING, MD permit. Pages 1 and 2 sl Department of Health an Important: If Item 27 is 1 any Injury or other trau 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CAREYSBURG, LIBERIA 11/21/09 CHURCH CEMETERY 22. Name and Address of Facility of Auneral Service Lice CAPITOL MORTUARY CUI 425 MARYLAND AVE., NE WASH., DC 20002 Approximate Interval Between Inset and Death blications that caused the death. Do for enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** Cance /Medical Due to (or as a consequence of) Examiner reumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 ☐Yes 2 No 1 Yes 2 No

Box 68760 P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be ဂ္ Certification:

25. Was case referred to medical examiner? 2 No 1 Tyes

27. Manner of Death Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be

3 Suicide 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital: 12 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

General Hospital, Olne-

29d. Date signed (Month, Day, Year)

Mont 9 omery 32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 2009 35587 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 25 P M **Physician** SILBERT 03 NOVEMBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE REHABILITATION EXTENDED CARE n/a BALTI MORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Apr 21, 9. Birthplace (State or Foreign **Funeral** MaryTand 220-12-5006 86 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show ir than "natural", or items 23a or 28a-f sho the Modical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 U.S.A. 521 Little Current Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite may niury or other traumatic event, the Modical Extending once. 1XXYes 2 □ No If Yes, Give 143-146 Year or Dates: 43-146 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo White Specify: þ 3 € Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>President</u> Exterminator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Stover Helen Hoover ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark M. Stover-son 521 Little Current Dr., annapolis, MD 21409 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 11/5/09 4 □ Donation 5 □ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AMERY DISEASE **Physician** CORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> DEMENTIA 1 Tyes 2 No 3 Probably 4 Donknown Completed ANGURYSM ADRTIC 24b. Were autopsy findings available prior to completion of cause of death? ABDOMINAL 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 24 hours after death.

Funeral Director: After this letely filled in by the funeral dil 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30272 NOVEMBER 03, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BOULEVARD BATTIMONE, MALKAND ZIZIS THOMAS S.MILLER, MD 31. Date filed (Month, Day, Year) State NOV 05 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Mary	cand / Dep Ce	artment of H rtificate of L	ealth and Me Death	ental Hygie Reg		35588
	Physici /Medio		1. Decedent's Name (First, Middle, Last) ANNI E		TRA			2. Date of Death Month	Day Year 3/ 2009	10-10-1
1	Examin	er	4a. Facility Name (If not institution, give s Good Samaritan			Baltim	Location of Death		4c. County of Death	1
	Funeral Director		2-10 10 5000	7. Age (fr	yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 12-26-	9. Birth 1912	nplace (State or Foreign untry) N . C .
	/land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	e Man	ctor	MD MD	I/A	Baltim	ore				X Yes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	eath y	Funerai	1512 Rutland A	venue 12. Was Decedent Eve	r in U.S. 13.		. 213 spanic Origin? (Spec n, Mexican, Puerto R	ifv Yes or No-	USA	rican Indian,
Maryland 21215-0036	within 72 hours efter death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:			n, Mexican, Puerto R Specify:	ican, etc.)	Specify: B	o, etc. Slack
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g	be filed tal Hygid d other event, I	BeC	7th grade 17. Father's Name (First, Middle, Last)	unk		Ĭ.	18. Mother's Name			
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Mar	7 12		19a. Informant's Name/Relationship (Ty)				and Number or Rural d Street			
	Heel Her		Mary Grandy-Nie 20a. Method of Disposition	2		osition (Name of ornatory or other place			c. Location - City or	
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Baltimore,	permit. Peges Depertment of t Important: If ite eny injury or or once.		21. Signature of Funeral Service License	98	2	2. Name and Addres	ss of Facility M North A		ast F/H BALTIMOF	21202 RE, MD
X.	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Proba	.6/e 1	ter the mode of dyin		respiratory arrest		Approximate Interval Between Onset and Death
ı	Examiner		Sequentially list conditions.	Due to (or as a co						
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Ć,	fficate be executed g physician and ss the burial-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):					
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Δ.	es thet igned b be deta	by Pł	Part II. Other significant conditions cor	ntributing to death but n	ot resulting in the I	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sig should b							1 ☐ Yes	2 € No 3 □ Pro	obably 4 Unknown
of Vital Records,	G CT	Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Vita	Physician: 'this certifica	o Be	25. Was case referred to medical examiner?	lospital:	2C 52/0	othe Othe	26. Place of Death			
		-	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	III 3L DOA	4 priursing nom	e 5∐Residend 8d. Describe how	e 6 □Other (Specinjury occurred	cify)
ion	Mtending I death. ctor: After y the funer	atio	1 Adural 5 Pending investigation	(Month, Day Ye	nar) Injury		Yes 2 □No			
Division	al or Attending s efter death. il Director: After ed in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5		treet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospital or Attendin 24 hours efter de To the Funeral Directo completely filled in by the	edicai (Check only one)	nician: To the best of more: On the basis of exa and manner stated	amination and/or ir	th occurred at the tim nvestigation, in my or	e, date and place a pinion, death occurre	nd due to the caused at the time, date	sa(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	Bake	MI	29c. License	SSI O	290	Date signed (Monti	31 2009
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print) 1 60 (60	h Raver	Blid	Balti.	nore
	Sta Registi		31. Date filed (Month, Day, Year)	B2. Registrar's	Signature	del				
-			WILL OR PASS	Part I	110					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6,25AM Physician/ Nember 0 res 2009 0 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NSV '2 ore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F (Month, Day, Country) 3332 Months Days Hours Min. Director nn Usual Residence of Decedent show 10b. County partment of Health and Mental Hygiene. sortent I fitem 23a or 28a-f show sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2 No 21215-0036 72 hours after 1 Yes 2 No If Yes, Give Year or Dates. Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industr (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surpame) ပ roThe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) -daughte 40 a Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 remation 3 Removal from State 7-09 metro onsville 4 ☐ Donation 5 ☐ Other (Specify) remator permit. 340 22. Name and Address of acility ire of Funeral Service Linense Balto, md, 21229 ola 23a. Pac 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Approximate Interval Between Onset and Death amplications Physician/ vascular disease or condition resulting in death) 2005 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Ao Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 0 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 2009

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Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORAT

31. Date filed (Month, Day, Year)
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			for State Registrar	tate of Ma	aryland		artment of F ctificate of I		Mer		giene Reg. No.	200	0 25	500
			Registrar Decedent's Name (First, Middle, Last)							Date of Dea	ath	<u> </u>	3. Time	of Death
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	Funeral		5. Social Security Number 6. Sex		e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8.	Date of Birt (Month, Da	th y, Year)	9. B	irthplace (State Country)	or Foreign
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	ryland how	_	10a. State 10b. County		10c. City	, Town or Lo		500					10d. Inside	City Limits
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36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show wit, it is Medical Examiner must be notified at	by Funeral		Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2 👿 No	lispanic Origin? (san, Mexican, Puer Specify:	Specify rto Rica	/ Yes or No an, etc.)		14. Race - Ar Black, Wh Specify:	nerican Indian, ite, etc.	
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<u>စ</u> ်	s 1 and f Heali item 2 other		Wykesha Tripp 20a. Method of Disposition		20b. P		sition (Name of matory or other place		Date				or Town, State	
<u> </u>	Pages ment o ant: If i		1 🔀 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State			aptist Church	i.	10/	/31/09		Java,	Virginia	
Baltimore,	Departi mport mport any inj		21. Signature of Funeral Service Licensee		-10	22	2. Name and Addre	ss of Facility rothers Fundataw Place F	eral S	Service,	P. A.			
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and a	Physician		Immediate Cause (Final disease or condition	meta		. 9	colon (Onset and	Death
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٠ <u>٠</u> .	law requires that the de as been signed by the 2 should be detached	by Ph	Part II. Other significant conditions contril	outing to death b	out not resu	ilting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco u	ise contribute	to the cause o	f death?
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Ita		Be C	25. Was case referred to medical examiner?				1625	26. Place of De	eath (C					
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	e Hospit 24 hours e Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine		of examina									e(s)
	To the within To the comp	Me	29b. Signature and title of certifier	100	- >1		29c. Licens	se number			29d. Da	te signed (Mo	onth, Day, Year)	
)			(Uldefell -	MULL.	TW W	10	Reint	25-0	0		10/	27/0	6664	
			30. Name and address of person who comp	MD (OD N	WOLFE	Street	Baltim	ore	MD	212	87		
	Sta		31. Date Ned (Month, Day, Year)	32. Registr	rar's Signa	ture								
	Registr	all	NOV 0 5 2009	1	- 4	1 6-	Mad.							

DHMH 17 Rev 1/2001

09-08481 Cameron Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35591

		1- For State Registrar			Certi	ficate of	Death				eg. No.			2223
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)					iams		1	Date of Dea Month Novembe	Day '	Year	3. Time 2200	of Death O hrs
		4a. Facility Name (if not insti	ution, give st	reet and number	-)		b. City, Town, or L	ocation of	Death			nty of Death		
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Funeral Director		5. Social Security Number 220-81-8444	6. Sex	7. A	ge (In yrs. las 1	t birthday) Yrs.	Months Days	If Under Hours	Min.		m (MM/DD/Y) -2008	Coi	untry)	State or Foreign
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003 withir giene.	dwo	17. Father's Name (First, Mi	/a		n/a				Name (I	First Middle.	Maiden Surna	ame)		
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	Be C	Sancho Wil		. Sr					ier		Peatar			
212 ould be Ment mark	To E	19a. Informant's Name/Rela				19b. Mailing	Address (Street						e, Zip Co	de)
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland, ment offers the Mantal Hygiene, ment of Meath hand Hygiene, marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner, must be notified at once, or other traumatic event, the Medical Examiner, must be notified at once.		Sancho Wil	liams	Sr-F	ather	1270	Kitmo	ore I	Road	Ba	lto, Mi	D 212	239	N-1-
ore, slan of Heal of Heal of ten		20a. Method of Disposition 1 X Burial 2 Crem	ation 3	Removal from S		ace of Dispos ematory or otl	ition (Name of center place)	netery,		Date	20c. Locat	ion - City or	· Iown, S	otate
Page Page nent o		4 Donation 5 Other	r Specify:		KIr		orial E						tow	n, MD
Baltimore, MD 2 permit. Pages I and 2 should Department of Health and M Important: If item 27 is an injury or other traumatic.		21. Signature of Funeral Se	vice Licensee	9		22. N	lame and Address				EastF/			D 0100
		23a, Part I Enter the diseas	e, or complica	ations that cause	ed the death.	Do not enter t	1101 E.	such as ca	rdiac or i	h Avenue Balto, MD 2120 correspiratory arrest, shock, or heart Approximate Interval Between Onset and				
Physician /Medical		failure. List only one c	use on each										Betw	een Onset and Death
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760, icate be exegiple by physician at the burial -	/Medical	UNPENDED IF FEMALE:		23c. If yes, out	come of pregn	ancy					23d. Da	ate of deliver	rv	
876 rtificat ing phy as the	J'E	23b. Was decedent pregnan past 12 months?	in the	1 Live birth		2 Fe	etal death 3	Ectopic	pregnan	ісу			Day	Year
Box 68 as death certificate at the attending ed for use as (siciar	1 Ves 2 No 9	Unknown		at time of dea	eth 5 O	ther (Specify)				1			=
D. Be t the de by the ached f	Phys	Part II. Other significant c		9 Unknown		sulting in the	underlying cause g	jiven in Pa	rt I.	23e. Did	tobacco use	contribute to	o the cau	se of death?
, P.O rres that t signed b	ğ	1								1Y	es 2 🗸 No	3 Pro	obably 4	4 Unknown
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e law e has b	ldm	-								per	formed?	death?		2 No
tal Rection: The certificate ector, page	ပိ	25. Was case referred to m	edical				26.Place	of Death	(Check o		2 110			
Vital hysicians this certi	i co	examiner? 1 ✓ Yes 2 No	Hos	spital: 1 Inpa	atient 2	ER/Outpatien	t 3 DOA	Other ₄	Nursing	Home 5	Residence	6 Othe	er:	177
n of ing Ph After t funeral	n: To	27 Manner of Death	-	28a. Date of I	njury sy,Year)	28b. Time of		ry at Work	- 19	28d. Describ Subject as	e how injury o	ccurred		
trendi freath.	atio	1 Natural 5	Pending Investigation	Nov 1, 200	9	UNKNOW		Yes 2 ✔	No	نب				
Division tal or Attendirs after death.	Certification:	3 Suicide 6	Could not be determined				eet, factory, office b	uilding, et		or Town				ite Number, City
Div ospital or hours afte ineral Dir	Ö	4 V Homicide		1	/Julti-Famil		rred at the time, d	ato and pla						
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only one) 2 Medica	Examiner: 0	n the basis of e	examination ar	dor investiga	ation, in my opinior	, death oc	curred at	t the time, da	te and place,	and due to f	the cause	e(s)
To To com	Med	29b Signature and title of o		nd manner state	ed.		29c. Licens	e number			29d. Date	e signed (M	ionth, Da	y, Year)
		lalle	1	CC	1	1_	O.C.	M.E.			Novem	ber 2, 20	009	
		30. Name and address of p												
		Zabiullah Ali, M.D		ant Medical			nn Street, Balt	imore, N	MD 212	201				
S Regis	stra	31. Date filed (Month, Day	2009	82. Regis	strar's Signatu	para				_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Care lawor 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Month Pay, Year 92 1 🗆 M 2 💢 Months Country) Director iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Widowed 4 ☐ Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NET use retired) day (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) မှ 19a. Informant's Name/Relationship (Type, Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Important; It any injury or 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses mois 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b, Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death should be detached 9 | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of page 2 After this certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2**V**Z No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Mayner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Natural work? within 24 hours after death.

To the Funeral Director: A 2 🗆 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 28a) (Type, Print)

NA DAUGE 821 N. EW OU 30. Name and Baltimore ed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

	For State	State of Ma	•	Certifica			Wental n				
	Registrar			Jerunca	tie oi i	Deam	0.0-4	Reg. No.	20	09	3550
an eal	1. Decedent's Name (First, Middle, La. Joan Kay V						2. Date of D	3 Day	2009	9	3:15p м
	4a. Facility Name (If not institution, giv			4b. Cit		Location of Dea		4c.	County of De		re
	2012 Calvert 5. Social Security Number 6. S		(In yrs. last birth	iday) If Und	ier 1 Year	I CITIOI E		irth			
	218-28-0612	M 2 XF	77 Yr	Month		Hours Min		3, 19	31	Countr	ace (State or Foreig
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	or Location						100	d. Inside City Limits
ctor	MD Baltir				timo	re					1 □Yes 2X No
I Director	10e. Street and Number 2012 Calvert	Court		10f. Z	Zip Code	21234		10g. Cîti	izen of What USA	Countr	ry?
Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec	cedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or N	10-	14. Race - A		
	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☑ N	0				rto Rican, etc.)		Black, W		
b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2 X No	Specify:			Specify: V	Whi	te
ted	15. Decedent's Ed	ducation	16a. D	Decedent's Us	sual Occup	ation	rekina	16b. Ki	ind of Busine	ss/Indu	ustry
mpleted	(Specify only highest gra	College (1-4or 5+ 5 +	. '/	Give kind of v life. DO NOT Feach (use retired	during most of wo d)	orking	Bal	timoı	re	County
ပ္ပ	17. Father's Name (First, Middle, Last,					18. Mother's Na	me (First, Middi				<u>-</u>
Be	Lynn A. Swee						M. Wil				
은		<u>-</u>	106.9	Mailing Add-	see /Stract	and Number or F				te Zin (Code)
	19a. Informant's Name/Relationship		1	•	•						
	James R. Whit	lock /nus		_		rt Cour	Date	_	ocation - City		
	20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ 4 □ Donation 5 □ Other (Specif		20b. Place of E cemetery, Bayvie	, crematory o	r other plac	ory 11	/4/09		timo:		
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al Examiner		b. Due to (or as a	the denth. Do not e	c c .= f):	node of dyir	y Funer ng, such as cardia	al Hom	e_of	Esse	ex	21221 Approximate Interval Between
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DHMH 17 Rev 1/2001

Registrar

09-08442 William Walper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35594

		- For State Certificate of Death	Reg	g. No.	003 3333
Physician		Decedent's Name (First Middle Last)	. Date of Death	Day Year	3. Time of Death
ledical Examin			Month October 31		1125 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	
		4612 Walther Avenue Baltimore 5 Social Security Number	C Data of Birth	N/	A Birthplace (State or Foreign
Funeral	1	Months Days Hours Min			Country)
Director		216-38-4155 1XM 2 F 70 Yrs. Notities 503 Notities 103 No	SEPT.	16,1939	MD
b .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ow any	1	MD N/A BALTIMORE			1 Yes 2 No
Maryland 28a-f show 1 at once.	힑	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	44
Mar or 28a	Director	4612 WALTHER AVE		USA	,
- 40 -		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-		merican Indian, Black,
ath w ltems	ā١	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R		White, etc	
ter de	리	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	WHITE
urs af tural	ᇍ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo		16b. Kind of Busine	ess/Industry
72 hor al Exi	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ed)		YT 66
036 ithin ne.	립	6 PURCHASING MANAGER		ELECTRO:	NICS
5-0 led w Hygie other		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, M	faiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. narked other than e event, the Medica			4. MOULI		7. O-d-)
D 21 should and Me 7 is ma	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re			1
ore, MD 21215-0036 s. I and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than her tranmatic even, the Medical	ŀ	DAVID WALPER-NEPHEW 5514 DAYBREAK TERR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	BALT. Date	IMORE, MD 20c. Location - Cit	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or import or other traumatic event, the Medical Examiner		1 y Burial 2 Cremation 3 Removal from State crematory or other place)			
Lim Pag ment tant:		4 Donation 5 Other Specify: DRUID RIDGE CEMETERY 11/	/4/09	BALTIMO	RE, MD
Baltimore permit. Pages I Department of I Important: If injury or other	-	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MII 6415 BELAIR RD		ORE, MD 2	
Physician	+	23a. Rait I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval
/Medical		fahure List only one cause on each line.			Between Onset and Death
(aminer		Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUISHOT WOUND OF HEAD Due to (or as a consequence of):			
		Sequentially list conditions,			
	<u><u>e</u></u>	if any, leading to immediate Due to (or as a consequence of):			4
		(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
760, frate be executed the burial - transit		d			
e execian a	Medical	UNPENDED AMENDED			
760, reate be physici the buri	ŝİ,	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	
68. certifi nding se as	Ë	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnar 4 Pregnant at time of death 5 Other (Specify)	ncy	Month	Day Year
Box 68 c death certifi the attending ed for use as	Physician	1 Yes 2 No 9 Unknown g Unknown			
D. Entrine of		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death?
P.O. es that the signed by be detac	و و		1 Yes	s 2 🗸 No 3	Probably 4 Unknown
rds requi	Completed		24a. Was		re autopsy findings available or to completion of cause of
e law e has ge 2 sl	g.		perfo	rmed? dea	th? Yes 2 No
R Th		25. Was case referred to medical 26.Place of Death (Check of		2 10 1	
lirecto	m	examiner? [Hospital: 1 Innation: 2 FR/Outpatient 3 DOA Other Nursin	g Home 5	Residence 6	Other: Scene
of V g Phy fter th	<u>۽</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		how injury occurred	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. In Director: After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should	틹	Natural 5 Pending POUND: FOUND: 1 Yes 2 No	Subject sho	ot seit	
/iSi r Attr ter de irecto	일	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town, S		or Rural Route Number, City
Dital of printing	Certification:	4 Homicide determined (Specify) Townhouse / Rowhouse	4612 Walther	Avenue , Baltimo	ore , MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only)	due to the caus	se(s) and manner as	s stated.
To the within Fo the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t the time, date		(Month, Day, Year)
	Σ	29b. Signature and title of certifier 29c. License number		November 1,	
		UUEIZ O.C.M.E.		140 Verilber 1,	
		 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 	1		
Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			
Registi		NOV 05 2009 Que B. parket			

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. **Physician** 2009 26, 1215PM HELEN WOOD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/30/1950 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours Min. MARYLAND 1 □ M 2 1 X F 59 213-56-2449 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show items 23a or 28a-f show 1 Yes 2 No PRINCE GEORGE'S CAPITAL HEIGHTS Director MD with the Og. Citizen of What Country? 10f. Zip Code 20743 10e. Street and Number 507 71st by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after iffour c.c. ... nd Mental Hygiene. s marked other than "natural", or if 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 □Yes 2 →No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. HELEN HEARD JAMES W. LANCASTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 71st St. CAPITAL HEIGHTS, MD. 20743 THOMAS WOOD/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopation 5 □ Other (Specify) HARMONY MEM. CEM. 11/2/09 LANDOVER, MD. of Funeral Servic Licen 22. Name and Address of Facility CAPITOL MORTUARY 21. Signa vi 1425 MARYLAND AVE., NE WASH., DC 20002 23a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FATAL CARDIAC ARRYTHMIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Physician/Medical Examine aftending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an cate has I autopsy performed? After this certificate funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation ours after death. ieral Director: Aff filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) determined 4 Homicide 24 hours 29a. Certifier LC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU6478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

DR.

SURESH PATEL

NOV 05 2009

31. Date filed (Month, Day, Year)

7501SURRATTS RD. 2. Registrar's Signature

#307 CLINTON, MD. 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31, 2009 **Physician** 7:55 Joseph Albert Yanchik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 31 Culmore Court Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 29, 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Months Days Year) 1933 Yrs. 161-26-5343 76 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examber must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 31 Culmore Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Loyola College, Balt. V.P. Student Affairs other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F marked Joseph Albert Yanchik Anna Tique 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar 0 wife 31 Culmore Court; Timonium, MD 21093 Carol Yanchik Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) = 5 permit. Page: Department o Important: If i any injury or St. Mary's A.O. Cem. 11/4/09 Hanover Township, PA 6 ☐ Other (Specify) 21. Signature of Fineral Service Lig 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC HERHEL CELL CARCINGULA Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) KI NEUTIF Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-t Box 68760. attending physician by Physician/Medical as the IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 - Ectopic pregnancy ō Month Year 5 Other (specify) 0 ☐Yes 2☐No detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 2 24 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 1 Yo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DCC1373 NOV 2 2009

30. Name and address of person who completed cause of death (Item 23a 47 pe, Print)

Tausen, MARYLAND

Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar determined

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #30 per DVR g897 11/5/02 er fificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2009 San /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town 4c. County of Death Examiner 6970 MARSUE DRIVE #2A BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) UKRAINE 5. Social Security Number 219-47-3805 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 0272871933 76 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Modical Evaminer must be notified at 1 ☐ Yes 2 🛛 No MD BALTIMORE BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 6970 MARSUE DRIVE #2A 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∭No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC **METALS** 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DANIEL ZHELEZNYAK BETYA ျှ LACHINSKYA Department of Health and Milmportant: If item 27 is mark any Injury or other traumations. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAINA GENDINA / DAUGHTER 115 OLD PLANTATION WAY, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI Bonation 5 Other (Specify) 11/04/2009 OWINGS_MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a onsequence of) e idded Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the a should be detached f □Yes 2□No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 sl autopsy performe 1 ☐Yes 2 ☐No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Mo

DHMH 17 Rev 1/2001

21208

AKUBA 2 Resevoir Circle Suite 105 Pikesville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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-UE

3. Registrar's Signature

TRYSUL

nth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0415 Dorothy Bertha Anders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** & MORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 5 1916 ALBO AT EASTON ASTON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Maryland Hours Min. Director 212-07-9115 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No Ridgely Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America <u> 21660</u> 309 Park Avenue items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Caucasian Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Institution Investment Broker 11 HS grad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridgely, Maryland 21660 309 Park Avenue, James D. Anders Husband Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dover, Delaware 10/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence off. Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 cate has been signed by the page 2 should be detached 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မှ this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🚧 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 8865656 200 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

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			For State	State o	f Marylan					nd M	ental Hyg	giene	0 0 0	2	05500
			Registrar 1. Decedent's Name (First, Middle, L	aet)		Cer	tificate	of De	eath			Reg. No	2009	_	35599
	Physicia Medic		Ann	S			Ausher	rman		(2. Date of Dea		0 200	9	3. Time of Death A
	Examin	er	4a. Facility Name (if not institution, g Washington Cour				4b. City, To			Death		4c.	County of Dear		
	Funeral	-			7. Age (In yrs. Ia	ast birthdav)	If Under 1	ersto Year	JWII If Under 2	4 Hrs.	8. Date of Birth		Washing		n ce (State or Foreign
	Director		101-20-9291	1 □ M 2 X) F	81	Yrs.	Months		Hours		Sept. I	Year)			land
	rd now	ڀ	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							104	. Inside City Limits
	larytar 3a-fsl ified	ectc	MD Washi	noton		gerstov								l loa.	1 X Yes 2 □ No
	the M	I Dir	10e. Street and Number	16011	1108	501300	10f. Zip C	Code				10g. Cit	izen of What Co	untry	?
	h with ns 23a nust b	Funeral Director	1116 Carroll He	ights Blv	7d.		2	1742					U.S.A	•	
	r death		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed For		5. 13. V	Vas Deceder f Yes, specify	nt of Hisp / Cuban,	anic Origi Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit		
99	saftei raf", o Exam	q pe	3 X Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Give Year or Da	9	1	☐ Yes 2	X) No	Specify:				Specify: W	hit	e
2-0	2 hour "natu edical	plet	15. Decedent's (Specify only highest				lent's Usual (of workin		16b. K	ind of Business	_	
12	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12)	College (1-	4 or 5+)		O NOT use re		mg moor t	or woman,		Do	omestic		
<u>d</u>	iled wi I Hygik other /ent, <u>t</u>	Be	17. Father's Name (First, Middle, Las	:t)				1	8. Mother	's Name	(First, Middle, I				-
ylan	ld be filed wental Hygiarked otheratic event,	욘	George W. Schoo	olden					Gert:	rude	A. Bla	nk1	ine		
Maryland 21215-0036	should I and Me 7 is marl raumati		19a. Informant's Name/Relationship									•	Town, State, Zi		e)
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Sundra L. Ware/	Daughter	20h F	389 1			n Ro		Bedford		A 1552 ocation - City or		State
altimore,	Page 1 ment of ant: If ii ury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State C	emetery, cren t Have	natory or other	er place)	. 1		2009		gerstown		
a ≣	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Lice										neral (
m	o a L E G		> J. Mark Su	7/0		1	601 Pe	ennsy	ylvan	nia A	Ave., H	ager	stown,		
			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	on bleations that c y one cause on each	aused the death th line.	h. Do not ente 7	er the mode o	of dying, s	such as ca	ardiac or	respiratory arre	est,		Int	pproximate terval Between
	Priysician/ , Medical		disease or condition resulting in death)	a. Due to (or as a consequ	vence of:	MON	ua						2	nset and Death
_	¹ Examiner	L	Sequentially list conditions,	ь —											
	od sit.	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):							28		
	cecute and Il-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):									
09	be e) /sician e buria	dical		d											
9/89	tificate ng phy as the		IF FEMALE:	-								_			
	death certificate be executed the attending physician and ed for use as the burial-transit	ian/	23b. Was decedent pregnant in the past 12 months?		Birth 2 🗌 Feta	aldeath 3							23d. Date of de Month	livery Da	v Year
Box	eg pe	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unkn	ant at time of c	ieath 5 ∟	Other (spec	orry)						Du	y
<u>М</u>	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cau	use given	in Part I.		23e. Did to	bacco u	se contribute to	the c	ause of death?
ds,	aquires een sig ould b	ted									1 □ Y	es 2	□ No 3 □ P	robab	ly 4 V Unknown
Division of Vital Records,	The law requires that the safe has been signed by the page 2 should be detach	Completed									24a. Was a autop	sy	prior to	topsy compl	findings available letion of cause of
ř	ician: The law certificate has rector, page 2	Be Co	25. Was case referred to medical	1				26 Place	e of Death	/Check /	perfor	2 X No	1 Yes	2	Nο
Ĭ	nysicia nis cer direct	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗌	ER/Outpatien	_	Other:				ence 6	Other (Spec	ify)	
ot	ing Pt		27. Manner of Death 1 ✓ Natural 5 □ Pending	28a. Date of (Mont	of injury h, Day, Year)	28b. Time of injury	- 1	. Injury at work?			3d. Describe ho	ow injury	occurred /		
Sior	Attend death ctor: /	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be	of Injury - At ho	me, farm, stre	et, factory, o		s 2 🗆 N		8f Location (St	treet and	d Number or Ru	ral Ro	ute Number
DIV	tal or rs after al Dire		4 - Hornicide determine	buildin	g, etc. (Specify)					City or Town				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completed filled in by the funeral director,	Medical	(Check - 2 \(\subseteq\) Medical Exa	hysician: To the be	s of examination	and/or invest	igation, in my	opinion,	death occ	urred at the	he time, date ar	nd place,	and due to the	cause(s) and manner stated.
	To the within To the compl	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	urse Practioner: T	o the pest of my	, knowledge, c		icense nu	umber		2	29d. Dat	e signed (Monti	n, Day,	Year)
			Maryen g	Tond	7			D	28	365		11	-2-09		
			Manjen	o completed cause	of death (Item	23a) (Type, P	rint)	e 8	tree	1-1	tage	ustr	our re	10	21740
	Stat Registra		31. Date filed (Month, pay, Year)	2009 32. Re	getrar's Signat	ure A	Barel	0			9				
_		_		4		2 16. 22									

DHMH 17 Rev 7/2009

			Registrar	ems State of pe	Maryland	g 961 Ce	757/04/26 rtificate of	Death		giene Reg. No. 2 N	ng	35600
п	Physici	an	1. Decedent's Name (First, Middle	Dale	Alvin	Boy	ce		2. Date of Dea Month	ath Day	Year	3. Time of Death
-	/Medi	cal	A. Dale	Boyce					Octobe		2009	1527 M
*	Examir	ier	4a. Facility Name (If not institution			_		r Location of Deat	h	4c. County		
	Funeral		5 Secial Security Allember	land Medica 6. Sex 1≜ M 2□ F	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h Kaasi	Ltimo: 9. Birthpl	ace (State or Foreign
	Director		221-18-6052	1 . M 2 □ F	76	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 1-8-19)	33 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Laur	el,Delaware
	and		Usual Residence of Decedent 10a. State 10b. County		10c, City,	Town or Lo	cation				10	Od. Inside City Limits
	Maryi -f sho	tor	DE Suss	ev	Lau							1 □Yes Ž□No
	r 28a	Director	10e. Street and Number		Dau		10f. Zip Code			10g. Citizen of	What Count	ry?
	23a c	ral	32583 Pine Grov	e Road			1995	6		USA		
980	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Exercite at must be putified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For	2 □ No e		Was Decedent of H fYes, specify Cuba 1 □ Yes 2ሺ No		Specify Yes or No- to Rican, etc.)	14. Rac Blac Specifi	e - America k, White, e	
5-0	72 ho	etec	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usual Occup	nation during most of wor	rkina	16b. Kind of B	usiness/Ind	ustry
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work done OO NOT use retired ager	d)	9	Pot	ıltry	
73	2 should be filed very and Mental Hygin and Mental Hygin is marked other raumatic event, It.	To Be C	17. Father's Name (First, Middle, L Harley Boyce	ast)					me (First, Middle, et Whaley		ne)	
ary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	Г	19a. Informant's Name/Relationsh	ip (Type. Print)			ng Address (Street					Code)
	s 1 and 2 if Health item 27 i		Brenda James (I)aughter)			5 County					
Baltimore,	permit. Pages 1 Department of H Important: If iter any Injury or otf		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		tate 20b. Plac	ce of Dispo netery, cren	sition (Name of natory or other plac	i	Date	20c. Location -	•	
Ē	artme prtant lnjury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Odd		ws Cem. . Name and Addre		20.2009) Laure)() West		
Ba	permi Depar Impo any Ir once		2 Shows to	at - do	MIMAN	1	nnigan,Sh	,				-
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that ca	used the death.							Approximate Interval Between
4	Physician	i i	Immediate Cause (Final disease or condition	44000	picator	y fo	iluce				1 2	Onset and Death
	/Medical Examiner		resulting in death)		or as a consequer	no of):			1	- 11	(Ar	
		ia l	Sequentially list conditions,	b. to	or as a consequer	e br	ili uz	12	11/1/	1/1	MD	8 days
9	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2001010	n as a sonsoquer	100 01).		1.1	14. 112	ranco	a men	
ó,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (o	or as a consequer	nce of):		4	THICATION APPROVI	D BY MEDICAL EX	1	
	cate b physic the bi	dical	·	d				CER	I M see			
9 x	death certific e attending p d for use as	Physician/Me	IF FEMALE:	23c. If yes, outc	ome of pregnanc	v				OOA Da	ro of doliver	
. Box	death e atte	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live bi 4 ☐ Pregna	irth 2□ Fetal de ant at time of dea	eath 3	Ectopic pregnanc Other (specify)	у			e of deliver nth I	Day Year
P.0	at the by the tache	hys	9 Unknown	9 🗆 Unkno	wn					ļ		
Division of Vital Records, I	w requires that the de sbeen signed by the should be detached t	þ	Part II. Other significant condition	s contributing to dea	ath but not resultin	ng in the ur	nderlying cause give	en in Part I.	23e. Did to 1 □ Y			e cause of death? ably 4 □ Unknown
မင	≥ 20 00	Completed							24a. Was a			sy findings available
<u>~</u>		Sol							perfor 1 □ Yes	med?	leath?	
Zii	Physician : The lav r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			T Out		th (Check only or	ne)		
o	Phys r this ral dii	Certification: To	1 ☑ Yes 2 ☐ No 27. Manner of Death	1 ☑ In		Outpatien b. Time of	t 3 DOA Othe	4 LI Nursing H	lome 5 ☐ Resid)
0	Attending I r death. ector: After by the funer	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month	i, Day, Year)	Injury 1330	Work	Yes 2⊠No	J			
Vis	I or Attener after deatf Director: I in by the	iffica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e, Place o	of Injury - At home g, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow	treet and Numb	er or Rural	Route Number,
	ital or Arsafter al Directed in bried i	Cer		bi	s vard				32583 P	Ine Grav	e Rd.	Laurel, DE.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the base	sis of examination	dge, death and/or inv	occurred at the tire estigation, in my o	me, date and place pinion, death occu	e, and due to the	cause(s) and ma	anner as st	ated. the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Mec	29b. Signature and title of certifier	and manne	or stateu.		29c. License	e number	2	29d. Date signe	d (Month, E	Day, Year)
	onthy		1:00 (th)	ones			1023	522429	34	Ortino	- 15	2009
- 6	De De		30. Name and address of person w	ho completed cause	of death (Item 23	Ba) (Type, F	Print)				,	
			31. Date filed (Month, Day, Year)	- 33 5	outh (reer		Baltin	more, r	nd. 2	190	
	Sta Registr		OCT 21	2009	was signature	pa	eld					

			State of Maryland / Dep			
			Registrar	rtificate of Death		.No. 2009 35601
ı	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Margaret Jane Battista		2. Date of Death Month	Day Year 6:55 AM
a reco	Examin		4a. Facility Name (If not institution, give street and number) Coastal Itospice at the Lake	4b. City, Town, or Location of Death		4c. County of Death Wicomico
1/5			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		155-24-5436 1 M 2 F 76 Yrs.	Months Days Hours Min.	08-21-19	Country) New Jersey
	pu »		Usual Residence of Decedent			10d Inside Challinia
	aryla shov	5	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1
	the M	ect	MD Somerset Princess 10e. Street and Number		100	. Citizen of What Country?
	3a or	Funeral Director	11290 Old Princess Anne Road	10f. Zip Code 21853	Tug.	USA
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be rodified at	oy Fu	Armed Forces? 1 Never Married 2 Married 1 Yes No If Yes, Give 3 Widowed 4 Divorced Year or Dates;	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	rican, etc.)	Black, White, etc. Specify: White
21215-0036	2 hour	Completed by	15. Decedent's Education 16a. Dece	edent's Usual Occupation		b. Kind of Business/Industry
121	rithin 7 ne. han "r	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing	
2	led w Tygie her ti	S	7 none Ho	omemaker	e (First, Middle, Mai	wn Home
Maryland	d be fi ental } ked ot c evel	To Be	Harry Conning		t Conning	,
Z.	shoul nd M marl mati	ř		ng Address (Street and Number or Rur		
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	Jer /	Robert Battista/Son 806 S	Springfield Circle	, Salisbu	ry, MD 21804
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposemetery, cre	osition (Name of matory or other place)	Date 200	c. Location - City or Town, State
턡	artmen artmen artant: injury		4□Donation 5□Other (Specify) Salisbur	ry Crematory 10-2.		alisbury, Maryland
Ba	Physician /Medical Examiner		May 1 - 2 Million D	2.Name and Address of Facility Inman Funeral Home 1673 Somerset Ave		og Anno MD 21952
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only our cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between
may			Immediate Cause (Final disease or condition MALIGNANT	LUNG CARCIN	ours	Onset and Death
-/			resulting in death) Due to (or as a consequence of):			
	7 -		Sequentially list conditions, if any leading to immediate cause. Enter Underlying			
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events c.			
8760,	ficate be executed physician and s the burial-transit	dical E	Due to (or as a consequence of):			
687	tificate ig phy as the	ledic	a	, <u></u>		
30X	leath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
P.O. Box	the dea	by Physician/Me		Other (specify)		Month Day Year
٠, ص	s that ined by	y Ph	Part II. Other significant conditions contributing to death but not resulting in the L	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
org	w requires that the de been signed by the should be detached				1 ☐ Yes	2 No 3 Probably 4 Unknown
Rec	has by	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	ding Physician: The n. n. After this certificate h funeral director, page		25. Was case referred to medical	OC Plans of Pant	1 □Yes ≥	
>	ysicie s cert directa	o Be	examiner? 1 Yes 2 No		h (Check only one)	ce AOther (Specify) HOSPICR
<u></u>	ng Ph fter th	T:uC	27. Manner of leath 28a. Date of Injury 28b. Time of Month, Day, Year Injury		28d. Describe how i	
<u>S</u>	tendii leath. tor: Ai the fu	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	lor Att after d Direct d in by	Certification: To	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
_	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	evestigation in my opinion, death occur	red at the time date	and place, and due to the cause(s)
	To the within To the compl-	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
				D005840	o	10-21-09
	3		and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, CHUMW WAR S P. Do C 17 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Print) ? Charley	mo	21802
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hall		
	Registr	al.	161 23 2003 Remon p. p.			

Marguret

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		For State		State	OI Wai	ylallu / L	Jepa Car	rtificate	OI THE	allii a	triu ivi	lental Hy			19	3560	12
		Registrar 1. Decedent's Name	(Eint Middle	(ant)			Cer	uncale	OID	ealii		2. Date of De	Reg. No.			3. Time of Death	
Physicia	ın		Blanch		Rce	nner						Month	Day 21		ar	1329	M
/Medic		4a. Facility Name (If r				TIPE		4b. City, To	own orla	ocation of	f Death	OE.		County of E		1261	
Examin	er	Howard Co		_		tal		Colum		ocation o	Dodai			oward	· outil		
Funeral		5. Social Security Nur	mber	6. Sex	7. Age	(In yrs. last bir	thday)	If Under 1	Year	f Under 2	24 Hrs. Min.	8. Date of Bi (Month, D			Birthp	ace (State or Forei	ign
Director		220-09-36	515	1 □ M 2 🔀	F	90	Yrs.	Months	Days	Hours		6/6/19			PA		
pu v	- {	Usual Residence of D	Decedent 10b. County			10c. City, Tow	n or Loc	cation							10	Od. Inside Cîty Lîmi	its
laryla shor	5														'	1 □ Yes 2 X N	
the N	Director	MD II 10e. Street and Numb	Howard her			Ellico	tt (10f. Zip (Code				10g. Cit	izen of Wha	t Coun	try?	
with 3a or		3509 Dair		low Troi	1			2104					USA			•	
ms 2:	Funeral	11. Marital Status	_y val	12. Was D	ecedent Ev	er in U.S.	13. V	Vas Decede	ent of Hisp	anic Orig	gin? (Spe	ecify Yes or N		14. Race - A			
after or Ite	Ī	1 Never Marrie	d 2 Marri		Forces?)		fYes, specif □Yes 2		Specify:	, Puerto	Hican, etc.)		Black, V	Vhite, e	tc.	
ral",	d by	3 Widowed 4	Divorced		or Dates:			165 2	L2840	ореспу.				Specify:	Wh:		
72 h "natu	Completed	(Specif	15. Decedent fy only highes	's Education t grade complete	∋d)	16a	(Give	lent's Usual kind of work	done dui		of worki	ng	16b. Ki	nd of Busine	ess/Inc	lustry	
within ene. than	dmo	Elementary/Second	dary (0-12)	Colleg	e (1-4or 5+)	S		oo NOT use etary	e retirea)				Li	fe Ins	sura	ance Co.	
should be filed within 72 hours after death with the Maryland and Mental Hyglene. In Mental Hyglene. In maked other than "natural", or Items 23a or 28a-f show umatic event, I'm Medical Estanding Indias the notified at	ပိ	17. Father's Name (F	-irst, Middle, I	Last)					1.	8. Mothe	r's Name	(First, Middle	e, <i>Maid</i> en	Surname)			
d be ental ked c	To Be	Paul Land	raster							Erma	Lar	caster					
shoul ind M i mar	۲	19a. Informant's Nan		nip (Type. Print)	-	19b	. Mailin	g Address (_			al Route Numi		r Town, Sta	te, Zip	Code)	
and 2 ealth a n 27 Is		Howard Br	renner	/ Husba	ınd	35	09 I	Dairy	Val1	ey T	rail	, Elli	.cott	City	, MI	21042	
		20a. Method of Dispo		•□•		20b. Place o cemete	f Dispos	sition (Name	e of her place)		С	ate	20c. Lo	ocation - City	y or To	wn, State	
Pages 1 nent of H ant: If Itel ary or oth		1 XBurial 2 ☐ 4 ☐ Donation 5			om State	1				- 1	10/2	26/2009	Ma	rriott	svi	ille, MD	
permit. Departr Importa any Inju	Ì	21. Signature of Fun	eral Service	icensee M(1411											ly FH, In	iC.
90 E 2 9		1 Car	The				4	112 01	Ld Co	lumb	ia F	Pike, E	llia	ott Ci	Lty	, MD 2104	.3
		23a. Part 1. Enter the shock, or heart	e dis c ase, or a	complications th only one cause o	at caused to on each line	he death. Do	not ente	er the mode	of dying,	such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death	
Physician		Immediate Cause (F disease or condition	inal	a	septic	Shoc	K									5 day	4 5
/Medical Examiner		resulting in death)		Due	to (or as a	consequence	,	. 1								. \-	,
LAGIIIIIGI	7	Sequentially list cond	ditions,	b. perforated duodenal ylcer unknown Due to (or as a consequence of):								1					
ted nsit	xaminer	if any, leading to imm cause. Enter Underly Cause (Disease or in	ying njury	Due	to (or as a	consequence	OI).										
cate be executed obysician and the burial-transit		that initiated events resulting in death) La		c	to (or as a	consequence	of):									· · · · · · · · · · · · · · · · · · ·	
icate be e physician the buria	ia E			d													
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eath certific attending p for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent p				f pregnancy	. 2	Ectopic pre	ognancy					23d. Date o		,	
deat he att	sicie	in the past 12 m 1 ☐ Yes 2 ☐		4 □ P		ime of death		Other (spe						Month		Day Year	
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uires tha signed d be det	þ	Part II. Other signific	ant conditio	ns contributing t			L	- 1 1	1	í						ne cause of death?	
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Phys rahdis rahdis	<u>ا:</u>	1 ☐ Yes 2 ☐ N 27. Manner of Death	10	1	Inpatien ate of Injury		utpatien Time of	t 3 □ 196/	Bc. Injury a	4 🗀 Nu		me 5 Res 28d. Describe			Specif.	y)	_
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pit:				g Physician: To Examiner: On th		my knowledge											
Hos 24 hc Fun tely	.≌ ⊦		L Incaida													* *	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	one) 29b. Signature and ti		and r	nanner state			29c.	License r	number				te signed (A	/lonth.		

Registrar

State

Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nishi Rawat 1072 Little Patoxent Pkwy

31. Date filed (Month Car Year) 2009 32. Registrar's Signature

		·	1 - For Per Phys. Registrar 10-23-09Amend#2	State of Marylan 3a.Prt.IIPOCr	d / Depa <i>Cer</i>	ırtme <i>tifica</i>	nt of H te of L	ealth an D <i>eath</i>	d Me	ntal Hyg	gienez Reg. No.	2009	35603	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	BURGESS					2	Date of Dea Month	Day	Year 2009	3. Time of Death 9 11:30 A M	
	Examin		4a. Facility Name (If not institution, give s WASHINGTON ADVENT)			, Town, or	Location of D	Death	4c. County of Death MONTGOME					
	Funeral Director		5. Social Security Number 6. Sex 1578 80 6533		last birthday) Yrs.	If Under	or 1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day 18 05	1959	9. Birt	hplace (State or Foreign DC	
	h the Maryland or 28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD PRINCE GEORGES UPPER MARLBORO								10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	ath with the 23a or 2 uset be no		10e. Street and Number 215 GRAIDEN STRE	ET			ip Code 2077					en of What Co		
036	hours after death with the Maryland tural', or Items 23a or 28e-f ehow al Examiner over be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	li li	Yes, sp	edent of Hi ecify Cuba 2 Ho	spanic Origin n, Mexican, P Specify:	i? (Speci Puerto Ri	fy Yes or No- can, etc.)		4. Race - Ame Black, Whit Specify:		
21215-0036	i within 72 jene. rthen "nai the Modic	Completed	15. Decedent's Educ (Specify only highest grade Elementary(Secondary (0-12) 12th	(Specify only highest grade completed) (Give			ident's Usual Occupation skind of work done during most of working DO NOT use retired) INSPECTOR					d of Business/ RTMENT VEHICLI	OF MOTOR	
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	nd 2 lith a 27 ls		JOHN BURGESS / BROT	HER	215 G	RAID	EN ST		JPPE	R MARL	BORO,	Town, State, 2	774	
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item eny injury or othe		20a. Method of Disposition PD Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State GDE	Place of Disposementery, cren SNWOOD	natory or CEME	other plac TERY	10		-2009	WASI	ation - City or	J. DC	
Ra	permit Depar Impor eny in		21 Signature of Funeral Service Licensee 3005 12th STREET N.E. TWASHINGTON, DC 20017											
ÿ	Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) And Complete Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								Approximate Interval Between Onset and Death				
8/60,	the death certificate be executed by the attending physicien and crose as the burial-transit conditions and contract the contract	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):										
O. Box 6	w requires that the death certific been signed by the attending f should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \)	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic Other (pregnancy specify)				23	3d. Date of de Month	livery Day Year	
rds, P	requires that een signed b hould be deta	۵									acco use contribute to the cause of death? s 2 No 3 Probably 4 知Unknown			
I Kecords,	The lay ate has page 2	Completed	End Stage Renal I	Disease	ease				24a. Was an autopsy finding prior to completion death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No		completion of cause of			
VItal	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		-	Oth	35		Check only o				
To uc	ding After fune	llon: To	27. Manner of Death 1 Natural 5 Pending	1 Anpatient 2 2 28a. Date of Injury (Month, Day Year)	1 Sunpatient 2 ER/Outpatient			28c. Injury at 28 Work?		Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			ecify)	
DIVISION	Hospital or Attanding P 24 hours after death. Eunerel Director: After t itled in by the funera	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stra y)					on (Street and Number or Rural Route Number, r Town, State)				
	n 24 hours n 24 hours ne Funere	ledical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of my knower: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurre estigation	d at the timen, in my op	ne, date and p pinion, death	place, ar occurred	d due to the data the time,	cause(s) a date and (and manner a place, and due	s stated. e to the cause(s)	
	To the Ho within 24 To the Fu	Ž	29b. Signature and title of certifier	7			9c. License			1		signed (Mon	th, Dey, Year)	
•	_			MD			# (3795	3		10	19/09		
_	. 6		30. Name and address of person who co	mpleted cause of death (Item		Print)	DVENT	1125 1	1051	PITAL				
2	Sta Registr		31. Date filed (Month, Day, Year) OCT 2.3 2009	32. Registrar's Signa	iture									

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32, Registrar's Signature

LOOMINGDA

Registrar DHMH 17 Rev 1/2001

State

Gail T.Griffin

31. Date filed (Month, Day

Box 68760

P.O.

21771

1502 S. Main St./ Mount Airy, MD

Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35606 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October Philip Noble Brown Medical 2009 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Easton Memorial Hospital

5. Social Security Number 6. Sex at Easton Talbot If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Davs Hours Min. (Month, Day, Year Delaware **Director** 87 218-16-6544 April Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 27360 Possum Hill Road United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 1 √2 Yes 2 □ No 1942-If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 KNo Specify: Specify: Caucasian 3 Divorced 4 Divorced 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Nylon Manufacturing Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည t. Page 1 and 2 should b tment of Health and Me rtant: If item 27 is mark Lawrence Ellen _Noble Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Brown <u>27360 Possum Hill</u> Road, Federalsbur, Maryland 21632 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 ☐ Other (Specify) 10/30/2009 | Concord, Maryland Cemetery Sign tun of Funeral Service Licen of 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician. disease or condition resulting in death) ani Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director: After this certificate has I autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2 To the F only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) £\$65656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. TAGE 31. Date filed (Month, Day, Year) Registrar's Signatur State OCT 27 Registrar

DHMH 17 Rev 7/2009

A510+

Brown, Philip

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 20, 2009 Charles William Baker III 8:22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1932 9. Birthplace (State or Foreign Months Days Hours Min. 1X M 2 □ F Delaware 222-18-6018 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDMontgomery Potomac ty⊡Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9316 Mercy Hollow Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 No Specify: Specify:White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Securities Executive NY Stock Exchange 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Baker II Elizabeth Holladay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Rand Baker / Spouse 9316 Mercy Hollow Lane Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) National Crematory 10/22/2009 | Falls Church, VA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 28 Years Immediate Cause (Final Coronary Artery Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Dav pecify) 23e. Did tobacco use contribute to the cause of death? ause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, II and once.

Physician

/Medical

Examiner

Director

Funeral

<u>و</u>

Completed

Be

Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

Funeral

Director

r than "natural", or items 23a or 28a-f show

within 72 hours after

Baltimore, Maryland 21215-0036

executed sician and burial-tran Hospital or Attending Physician: The law requires that the death certificate be 8 filled in by the funeral director, page 2 should certificate After this

Box 68760

P.0.

Records,

Vital

Division of

1 □ Yes 2 □ N 9 □ Unknown	0	9 ☐ Unknown	t inne of death	3 □ Other (sp
		ontributing to death b	ut not resulting in	the underlying ca
Diabetes	mellitu	ıs, Renal	Failure	į

		24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 24b. Were autopsy findings availat prior to completion of cause of death? 1 □ Yes 2 □ No							
25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing I	ne 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day, Year) n	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier CertifyIng Pl	hysician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.							

29a. Certifier
(Check onl
one)

and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D21115

29b	o. Signa	ature and title	of certifier		. ,	
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	h1		-4	Variable	11	-

29c. License number 29d. Date signed (Month, Day, Year)

10/21/2009

death (Item 23a) (Type, Print)

Lee R. Pennington MD 0215 Fernwood Rd. Bethesda, MD 20817

State Registrar

within 24 hours after deat To yo the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 9 Physician Mary E. Bouknight 2009 10 1:17pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** kever eo If Under 1 Year | If Under 24 Hpc 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 12/16/50 **Funeral** Days Hours 1 □ M 2 🛛 F **Director** 58 577-70-8773 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination to the Instituted at DC Washington 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20019 USA 3436 Dix Street NE Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②▼ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Black Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie M. Bouknight Mary E. Boyce 19a. Informant's Name/Relationship (Type. Print) brother
Roy Edward Bouknight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5420 Keniworth Terr #! Riverdale, Maryland Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Harmony Cemetery 10/29/09 Landover,Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Smedd Mortuary Service, P.A. 1409 Fairlakes Pl Steb Mitchellville, Md 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Arterioset Mearl eratic disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Day 5 Other (specify) his certificate has been signed by the a director, page 2 should be detached is 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVAdor

State Registrar 31. Date filed (Month, Day, Year)

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25 per phys. G899 1/26/10 dk
State of Maryland / Department of Health and Mental Hygiene 2000 35609 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** October 19, 2009 Reginald Boulter 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14202 Backbone Road Eden Somerset Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours Min 226-30-3475 81 07/14/1928 Virginia Usual Residence of Decedent 10b. County 10a State 10c City Town or Location 10d. Inside City Limits Director Maryland Eden 1 ☐ Yes 2 X No Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14202 Backbone Road 21822 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Myes 2 □ No
If Yes, Give AirForce
Year or Date AirForce 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance Moores Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Reginald J. Boulter Madvln Bonniwell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14202 Backbone Rd., Eden, MD 21822 Norma Boulter/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/21/09 22. Name and Address of Facility 21. Signature of Funeral Service Licen Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21822 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladde disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Ye ar 5 Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **Z** No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 □ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death To the Funeral Director: To the Hospital completely U.M ip State Registrar

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a INSTICAL ENVIROR ENTER INVITED BY A DOME.

Physician

/Medical

Examiner

the attending physician and ned for use as the burial-trar

detached

cate has been signed page 2 should be dete

certificate has

this

After 1

funeral director,

the

filled in by

29b. Signature and title of certifier

30. Name and address of person who

Jimmy Taylor,

OCT 22

31. Date filed (Month, Day, Year)

WD

2009

law requires that the death certificate be executed

Box (

P.0.

Records,

Division of Vital

or Attending Physician:

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

100 E. Carroll St.,

29c. License number

Salisbury, MD 21801

29d. Date signed (Month, Day, Year)

1 - For State Registrar

Be Completed by Funeral Director

ပ

Physician

/Medical

Examiner

Funeral

Please	Type or Print in E State of Marylan					_		•	
For State Registrar	State of Maryian		rımenı <i>tificate</i>			Memai	Hygier Reg. I		
Decedent's Name (First, Middle, La	ast)						of Death	200	9 3. 3n 5 f 6 at (
Ethel J. Beau	champ					Mont		Day Year	3 I I D M
4a. Facility Name (If not institution, gi	ve street and number)		4b. City, To	own, or Lo	cation of Deat	th	4	4c. County of Dea	ath
Manokin Mar	wr .		1-1-1	nces	sAnr	re		Domei	
	Sex 7. Age (In yrs. 1 1	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs Hours Min.	. (Mon	ith, Day, Yea	ar) C	irthplace (State or Foreign Country)
213-18-4727 Usual Residence of Decedent	3 3					6-2	1-19	10 MD)
10a. State 10b. County	10c. City	ty, Town or Loca	ation						10d. Inside City Limits
MD Somers	et Mar	ion St	tatic	on					1X Yes 2 □ No
10e. Street and Number			10f. Zip C				10g.	Citizen of What C	ountry?
28742 Schoolh			218	338			U.5	Ş.A.	
11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Deceder Yes, specif	nt of Hispa y Cuban, N	anic Origin? (S Mexican, Puerl	Specify Yes to Rican, et	or No-	14. Race - Am Black, Whi	
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give	11	□Yes 2X	No S	Specify:			Specify:	
15. Decedent's E	Year or Dates:	16a. Decede	ent's Hsual	Occupatio	n		16h	Black Kind of Business	
(Specify only highest gr	ade completed)	(Give ki	ind of work O NOT use	done durir retired)	ng most of wor	rking	100.	Milly of Deciment	s/IIIddaii y
Elementary/Secondary (0-12)	College (1-4or 5+)	House							
17. Father's Name (First, Middle, Last)			18	. Mother's Nar	me (First, M	liddle, Maid	len Sumame)	
Joe Teagle				1	Meliss	sa Te	agle		
19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing	Address (y or Town, State,	Zip Code)
Eleanor Braxt					Marion	ı Sta	tion	, MD 21	838
20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Section 21. Signature of Function 21.	fy) Dir	Place of Disposite metery, crematery, crematery	rema‡	LLC.	10-2	Date 26-20	09 Do	Location - City of	Œ
21. Signature of Funeral Service Lice	Kninde	Fur	neral	Hon	ne Sa	alisb	ury,	bella S MD 218	3,01
23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	Do not enter	the mode of	of dying, s	uch as cardia	c or respirat	tory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. 45CV	'							Oligot and Boats
Tooling in dealing	Due to (or as a consequ	uence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury	b Due to (or as a consequ	uence of):							
that initiated events resulting in death) Last	c Due to (or as a consegu	ience of);							
	_d	101100 0.7.							
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal							23d. Date of de	elivery
in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of do		Ectopic preg Other (spec					Month	Day Year
Part II. Other significant conditions	contributing to death but not resu	liting in the und	erlying cau	se given ir	Part I.	23e.	Did tobacc	o use contribute t	to the cause of death?
							1 🗆 Yes	2 No 3 F	Probably 4 Tonknown
							Was an autopsy performed?	? 🖊 death?	
25. Was case referred to medical examiner?				26	. Place of Dea				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA	Other:	Nursing H	lome 5	Residence	6 □Other (Spe	ecify)
27. Man of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	28b. Time of Injury	28c	. Injury at Work?	2 🗆 No			jury occurred	
3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Injury. At her	me, farm, stree	t, factory, of	ffice		28f. Locat City o	tion (Street a or Town, Sta	and Number or Rate)	Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exar	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death of tion and/or inve	occurred at estigation, in	the time, on my opinion	date and place on, death occu	e, and due t urred at the	o the cause time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier			29c. L	icense nu	mber		29d. [Date signed (Mon	oth, Day, Year)

9 23a. Part 1. Ente shock, or h Immediate Caus disease or cond resulting in deat Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death Medical Certification: To Be Completed by Physician/Medical Examiner IF FEMALE: 23b. Was deced in the past 1 ☐ Yes 9 Unkno Part II. Other sig 25. Was case reference examiner? 27. Man of De 2 Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signature a Nh 147094 10/20/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 NA TESAN 1415 STL 15 13 VILY 5-DIVISION SheLL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker Registrar OCT 2 2 2009 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Donald F. Currier Month 18 10 3000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Salis bary If Under 1 Year | If Under 24 Hrs. Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. 1 XM 2 ☐ F Days Hours 314-24-0385 81 Director 10/19/1927 Oklahoma Usual Residence of Decedent 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example made to confine at any injury or other traumatic event, the Medical Example made is notified at 10d. Inside City Limits Director Wicomico 1 ¥ Yes 2 □ No Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 E. Schumaker Manor 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Army 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 TNo Specify þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer engineering Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank J. Currier Josephine Bickell 19a. Informant's Name/Relationship (Type. Print)
Carolyn Currier/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 E. Schumaker Manor, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/21/09 Salisbury, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License HOTIOWAY TURETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE ALZHEIMER'S DEMENTI **Physician** 1 Rars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Box 68760 requires that the death certificate be Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has e 2 s autopsy performed? res 2 No page 2 this certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐Yes 2MNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) D 295-05 10-18-2009 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR. SALISBURY, MD 21801

1. Date filed (Month, Day, Year)

32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

OCT 2 3 2009

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 35613 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death oCTOBER 19 **Physician** HERBERT WALTER COLLINS 2009 12:22 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 6001 Muncaster Mill Road-Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Mar. 28 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 18 M 2□ F 219-12-2527 1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedgal Evan in a court be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md. Montgomery Gaithersburg 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20882 10001 Watkins Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: White WWII 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Construction Co. Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elmer Ε. Collins Grace ٧. Purvis ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Turner/Daughter 10001 Watkins Road, Gaithersburg, Md. 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/09 Neelsville, Md. Neelsville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Muriel H. Barber
P. O. Box 5038, 21. Signature of Funeral Service Licensee Funeral Home Laytonsville, Md. 20882 muriel H. Barker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 1∐Yes 2 🖬 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. Kouetcheu, m) 163748 October 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road, Rockville, Md. 20855 20+1 31. Date filed (Month, Day (Car) 32. Registrar's Signature State 21 Ceneur Registrar Darke

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2009 35614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 22, Dale 200^{ea} Susan Caracci 11:55 aM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10204 Lariston Lane Silver

If Under 1 Year | If Under Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 356-32-3064 68 Director July 14, 1941 Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10204 Lariston Lane 20903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 9 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed with and Mental Hygier 7 is marked other th Custamer Service Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Brettman Lucille Alberti ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau Anthony J. Caracci/Husband 10204 Lariston Lane, Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State October 23, 2009 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brain Tumor, Glioblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause that it would ge Cause (Disease or injury that initiated events resulting in death) Last ne Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi Exam and Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical nding p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 5 Other (specify) 1 ☐ Yes ned by the o 9 Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 🗆 No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 Tes 2 TNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation Injury nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier Medical 1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64983 October 23, 2009 30. Name and address of person who Kashif Firozvi, MD who completed cause of death (Item 23a) (Type, Print) ID 1500 Forest Glen Road, Silver Spring,MD 20910 31. Date filed (Month, Day, Year) . Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AUDREY JOANNE CARNEY 16, 2009 OCT. 2015 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖫 F Months Days Hours Director 213-42-5784 66 Mar. 6, 1943 Wash. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1y Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 2401 Lyttonsville Road 20910 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natiany Injury or other traumatic event. It is marked. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th Administrative Ass't H.E.W. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Gaither, Sr Thelma Granger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kyle Dawes (Daughter) 8505 Ingersoll Court, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 10/26/09 Silver Spring, MD 4 Donalion 5 Other (Specify) Gate of Heaven Cem 21. Signatur Funeral Service Licen 2. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Art 1. Enter the disease or complications that caused the death. Do now enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed hysician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 tending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown this certificate has been signed by all director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2-1No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 TNo 1. Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director; A 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057114 10119109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Rockville, MD 20850 Truong Bao, M.D. 31. Date filed (Month, Day, Year) State UCT 23 2009 Registrar

PATION CATE

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar **Physician** Joaquin Cabrejas 3:19 P M October 21, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Days | March Day 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Yea}1⁹24 Country) Cuba 578-60-4498 1 ★M 2 □ F 85 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or items 23a or 28a-f showniner must be notified at Maryland Montgomery Wheaton 1 ☐ Yes 2x No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural"; or items 23a or 2 any hijury or other traumatic event, the Medical Exeminer must be reporte. 20902 11919 Lafayette Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 1 X Yes 2 No Specify: Specify: White Cuban 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting CPA 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joaquin Cabrejas Angela Maria Sarmiento 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19108 Munger Farm Road, Poolesville, MD 20837 Cesar Cabrejas /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 27, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery Silver Spring, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signan re of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Trem (\$101527 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Decay of highly that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed Division of Vital 1 □ Yes 2 **X** No 2 XNo After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 21, 2009 D58862 20 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry Chilin Chu, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State UCT 23 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Fasure All Copies Are Legible.
Amend Item 26 per phys. G898 12/1/09 dk
State of Maryland / Department of Health and Mental Hygien 2009 35617 Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Roland Wesley Cottman, Jr. 10 7:48 a^M 16 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Westover Somerset 32030 Walt Johnson Road WESLOVEI

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth

Months Days Hours Min. | 3 - 21 - 1 9 5 3 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 1 **X**M 2 □ F 56 Yrs. 218-58-1144 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 XNo Somerset Westover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 32030 Walt Johnson Rd 21871 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Auto Detailer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roland Wesley Cottman, Sr. Survilla Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Collins/Sister 9221 Old Court Rd, Baltimore, MD 21244 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2009 Dover, DE Direct Cremation 21. Signature of Fune al Service Licen 22. Name and Address of Facility Bennie Smith 917 W. Isabella St Salisbury, MD 21801 Funeral Home 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UPT Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

/Medical Examiner The law requires that the death certificate be executed o Records, of Vital

attending physician and for use as the burial-transit signed by the a should I has page 2 certificate il Director: After this Division death. hours after To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Physician

/Medical

Examiner

10a State

MD

Director

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Completed

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Examine

Physician/Medical

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Completed

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Certification;

Medical

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

other

permit. Pages 1 and 2 s Department of Heatth ar Important: if Item 27 is any injury or other trau

Physician

1 and 2 should be Health and Mental is marked

death

within 72 hours after

Maryland 21215-0036

Baltimore,

Registrar

. Name d address f p rson who completed cause of death (Item 23a) (Type, Print) Janah State

29b. Signature and title of certifier

4 | Homicide

29a, Certifier

31. Date filed (Month, Day, Year)

OCT 2 2 2009

(LUS Penterm D Suite (UI, Scholing MD M 32. Registrar's Signature Dineum

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

NOON614

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day TheresA 650 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6. Sex Medical Confe 21 SAITIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ X Months Days Pennsylvania Director 35 Feb. 28, 220-96-2393 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits or than "natural", or items 23a or 28a-f show Director Harrington 1 ☐ Yes 2 No Delaware Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19952 872 Prospect Church Road Funeral United States of Ameri death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Teresa Laverne Sheppard ပ Townsend David Leslie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 872 Prospect Church Road, Harrington, DE 19952 Husband J.R. DeFord 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Denton, Maryland 10/28/2009 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery 21. Signature of Funeral Service t 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DWINE /Medical Due to (or as a consequence of): Examiner Adult Nespiratory Distrect Syndrone Sequentially list conditions, if any, reading to infine diete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) signed by the a P.O. 9 | Unknown g Unkn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ 1 Yes 2 Avo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Hospital or Attending Physician; The certificate 3 NO Division of Vital 2 No 1 □Yes 1 ☐ Yes this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No Certification: To I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death
To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1598967499 NPI 22 2009 oct 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC COX S. BALtimore Green MD 21201 31. Date filed (Month) distrar's Signature Day Year State OCT 26 Registrar DHMH 17 Rev 1/2001

OHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tem 5
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10-Hester Rebecca Dennis 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salis bary
If Under 1 Year | If Under 24 Hrs. Ni comico Hospice at the ousta Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Min. 218-20-3045 84 **Director** 1-6-1924 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be motified at 10d. Inside City Limits Director 1 XYes 2 No MD Worcester Stockton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5315 Paradise Rd 21864 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: Black 1 ☐ Yes 2 X No þ Specify 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Salisbury Elementary/Secondary (0-12) College (1-4or 5+) Custodian University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic ewonce. Burton Hall ဂ Lula Mae Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Paradise Rd, Stockton, MD 21864 Darnell Dennis/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Bapt Cem 10-24-2009 Stockton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith 917 W. Isabella St Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MALIQNANT BRRAST CARCINOU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of): certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 HNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wother (Specify) HOSPICR 27 Madriter of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation ul Director: A ed in by the fi 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20058410 10/21/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

6 Husan

31. Date filed (Month, Day, Year)

DET

WAR

22

BOX

32. Registrar's Signature

WD 2/802

09-08031 Leon Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35620

UII L Valis			or State	0.0.15	J	Certifica	ate of	Death				eg. No.		
Physic	an/	Regis 1. D	strar ecedent's Name (F	irst, Middle,Las	t)						Date of Dear Month	Day Ye	ear	3. Time of Death 0110 hrs
edical Exam			LEON	WELCH	EVANS						October 1	6, 2009 4c. County	of Dogst	
					e street and number)		41	o. City, Town, o	r Location of	Death		Somer		' İ
			122 Somers C						ar If Under	24 Hrs	9 Date of Ris			rthplace (State or
Funera			ocial Security Num		ex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Ye Months Da		Min.			I Foreig	gn ountry) MD
Director		219	9–44–2050	1 1	M 2 F	63	Yrs.				09/27	/1946_		COLICO (VILL)
			ual Residence of De			10c. City, Town	or Locatio	on.						10d. Inside City Limits
w any		10a	. State 10t	b. County		loc. Oity, romi	0. 20000		2.7					1 XYes 2 No
Aaryland 28a-f show 1 at once,	Þ	Μā	aryland	Some	set			Crisfi	.ета			10g. Citizen of \	What Co.	untry?
Mary 28a-	Director	10e	e. Street and Number						1017				US	
th the Maryland 23a or 28a-f sho notified at once,	ā			rs Cove	e Apartmen	ts	12 Wo	Decedent of H	21817	in? (Spe	cify Yes or N	o- 14. Ra		erican Indian, Black,
th with	Funeral	11.	Marital Status Never Married	2 Marrie	12. Was Deceden Armed Forces	?	If Ye	es, specify Cub	an, Mexican,	Puerto R	Rican, etc.)	W	hite, etc.	
r deat or it	교				1 Yes 2 d If Yes, Give Year	X No	1	Yes 2 X	lo specify:			Specif	y: Wł	nite
hours after 'natural'',	۾	1			or Dates: only highest grade co	mpleted) 16a	Deceden	's Usual Occur	ation (Give k	ind of wo	ork done	16b. Kind of		
hour "natu	ompleted	<u> </u>	Elementary/Second		College (1-4 or		during me	ost of working li	fe. DO NOT i	use retire	ed)	Somers	set (County
36 nin 72 fran			12	, (- /	5+			Teach	er			School		stem
d with	5	17.	. Father's Name (Fi	rst, Middle, Las								Maiden Surna	me)	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	1 -	Wells Wo	lfe Eva	ns, Jr.				Mary	Ros	se Weld	ch	Cta	to Zin Codo)
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "matural", or items 23a or 28a-f shunding and the Marked other han "matural", and the notified at once	٩	198	a. Informant's Name	e/Relationship	(Type, Print)	1	9b. Mailing	Address (St	eet and Num	ber or Ri	ural Route Nu	umber, City or T	owii, sia	A 22206
MD and 2 sho		L	eon Shan	e Evans	(Son)	Z Sob Black	1531	F . SOUT	n 28th	ROS	Date A	20c. Location	on - City	A 22206 or Town, State
Te l and l'Heal		20	a. Method of Dispo	sition Cremation 3	Removal from S		atan: or of	hor stace)				1		
Pages lent of		1	Donation 5			Sunny	ridg	e Memor	ial Pa	irk J	10/21/	2ψ09 Cr	ISLI	eld, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "		21	. Signature of Fund			Buill		Name and Addr		BRA	ADSHAW	& SONS	FUN.	ERAL HOME
യ ಕ್ರಕ್ತ		M	and here	Pracs!	aw-Pruitt	d the death Do	3	06 W. M	lain St	reet	respiratory a	isfield	heart	Approximate interval
Physicia		23	Ba. Part I. Enter the failure. List only	one cause on	each line.				g,					Between Onset and Death
amine			nmediate Cause (Fi		a. Complications Due to (or as a cor		Alcohol	Abuse		-				
					b.	isequenios or).								3
	à		equentially list cond any, leading to imn	nediate	Due to (or as a cor	nsequence of):								
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ecuted	nsit Evaminor	e/	vents resulting in de	eath) Last	d.	1004401100 01/1								
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redath. After this certificate has been signed by the attending physician and	ne burial - tra	<u> </u>	UNPENDED		AMENDED									
760, cate be exe	he burial		FEMALE:		23c. If yes, outo	come of pregnan	су						te of deliv	
876 tifica			b. Was decedent p		1 Live birth		2 F	etal death	3 Ectop	ic pregna	ancy	Mon	th	Day Year
Box 687 e death certific the attending	r use	231	Yes 2 N		- T	at time of death	5 C	ther (Specify)				ľ		
Bo he dea	hed fo	~ !			ns contributing to de		Iting in the	underlying cau	se given in F	Part I.	23e. Di	d tobacco use	contribute	e to the cause of death?
that t	detac	6	art II. Other signin	ount condition	io contained in the						1 🗌	Yes 2 No	3 F	Probably 4 🗸 Unknown
S, I	ld be	<u> </u>									24a. W		4b. Were	e autopsy findings available to completion of cause of
ord aw rec	2 shor	Completed									pe	itopsy erformed?	deat	h?
Rec The la	page	ě								(Ob - a)	1 🗸 Ye	s 2 No	1 🗸	res 2 10
al Fian:	ctor,	99 2:	5. Was case referre	ed to medical	Hospital:				Other		ng Home 5	Residence	6 🗸 C	Other: Scene
Vit hyste	al dire	0	1 🗸 Yes 💈	No	28a. Date of		R/Outpatie		Injury at Wo			be how injury o		
I of	funer		7. Manner of Death		(Month, Da		JD: 111110 0		Yes 2					
SiOr Attend death.	y the	<u>,</u> [≝	2 Accident	5 Pendir Investi		of Injury - At home	e farm sti				28f. Location	on (Street and I	Number o	r Rural Route Number, City
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rate death. al Director: After this certificate has been signed by	dinb	Certification:	3 Suicide	6 Could determ	not be	i injury - Actioni	c, ram, on	001, 100111, 7, 111				n, State)		
Spita hours	y fille		4 Homicide		(1,1,1,1)	of my knowledge	death occ	curred at the tin	ne, date and i	place, an	d due to the	cause(s) and m	anner as	stated.
Dithe Hospital hin 24 hours the Funeral	completely filled in by the funeral director, page 2 should be detached for use as i	@ ((Check only one) 2	Medical Exam	Iner:On the basis of	examination and	or investig	gation, in my op	inion, death	occurred	at the time, o	rate and place,	and dde	15 (1)0 00000 (1)
To the within To the	CONT	9 - 2	29b Signature and		and manner stat	ed.			cense numbe			29d. Date	signed	(Month, Day, Year)
		,	1	\bigcap	Pall	L.			C.M.E.			Octobe	er 16, 2	2009
		-	Name and addr	ess of person v	vho completed cause	of death (Item 2	3a)							
		'	Patricia Aro			nt Medical Ex		111 Pen	n Street, E	Baltimo	ore, MD 21	1201		
	Sta	ate 3	31. Date filed (Mon	th, Day, Year)	32. Reg	strar's Signature	1	1						
Pa	aisti			OCT 20	2009 /2		A. 4	ake)						

			1 - For State Registrar			artment of Health and rtificate of Death	, 0	ene g. No. 200	3562
	Physici /Medi		1. Decedent's Name (First, Middle, L Aubrey Elmer	ast) Flemi	ng		2. Date of Death Month Oct. 20,	Day Year	3. Time of Death 5:25 A ^M
-	Examir		4a. Facility Name (If not institution, g Heartfield Assist	,		4b. City, Town, or Location of Dea	ath	4c. County of Deal	
	Funeral Director				e (In yrs. last birthday) 98 Yrs.	Frederick If Under 1 Year If Under 24 Hi Months Days Hours Mii	s. 8. Date of Birth		hplace (State or Foreign untry) 71and
	/aryland f show	'n	10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits 1 □ Yes 2 X No
	vith the N a or 28a-	Director	Mary1and Howard 10e. Street and Number		Woodbine	10f. Zip Code	10	g. Citizen of What Co	
	er death v	Funeral	1521 Saint Michae	1s Road 12. Was Decedent E Armed Forces?		21797 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	SA 14. Race - Ame Black, White	rican Indian,
9000	nours afte ural", or i	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 □Yes 2 🕅 N If Yes, Give Year or Dates:	lo	1 ☐Yes 2 X INo <i>Specify:</i>		Specify:	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, it is Madical Examination ust be notified at	Completed	. 15. Decedent's Eigenentary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	6b. Kind of Business/	
	be filed that Hygied other event, I	Be	17. Father's Name (First, Middle, Las	t)	farme		ame (First, Middle, Ma	griculture aiden Surname)	<u> </u>
Maryland	2 should and Men is marke raumatic	2	James Elmer Flem 19a. Informant's Name/Relationship		19b. Mailii	Laura Es	stella Pic Rural Route Number,		lip Code)
	Pages 1 and nent of Health ant: If item 27 ary or other tr		Janette M. Knill 20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □		20b. Place of Disponsional Commetery, creen	Saint Michaels I	Road, Wood Date 26/2009	bine, Mary Oc. Location - City or	rland 21797 Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Action Examination, ust be notified anone.		4 Donation 5 Other (Special Signature of Pineral Service Lice	fy)	22	rings Methodist 2. Name and Address of Facility Mc 6401 Ridge Road,	Cem. Molesworth-	Williams F	Maryland uneral Home 20872
No.	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate us (Final disease or consider		ne death. Do not ent		ac or respiratory arres		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):				DAYS
68760,	rtificate be executed ig physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	consequence of):				
O. Box	attendin for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions					cco use contribute to	the cause of death?
Hec	sician: The law re certificate has bed rector, page 2 sho	e Completed	UNCONTROLIE 25. Was case referred to medical	D DIA	BETES.		24a. Was an autopsy performe	prior to c d? death?	opsy findings available ompletion of cause of
OI V	Physician: this certific ral director, p	m	examiner? 1 ☐ Yes 2 🛣 No		nt 2 ER/Outpatien	t 3 DOA Other: 4 Nursing I	ath <i>(Check only one)</i> Home 5 ☐ Residence	ce 6 🖔 Other (Spec	ify)Assisted
VISION	tending F leath. tor: After the funera	Certification: To	27. Manner of Death 1		Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	Living
2			4 Homicide determined	building, etc.			City or Town, S	•	
:	the Hos nin 24 ho the Fune	Medical	one)	niner: On the best of niner: On the basis of and manner state	examination and/or inv	occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	vitt To	2	29b. Signature and title of certifier	MD		29c. License number $D0061410$		Date signed (Month,	. ,
l	0		30. Name and address of person who			Print)		tober 20,	2009
	Stat Registra	е	31. Date filed (Month, Day, Year)	32. Registrar 1 2009 > /2	s Signature		aryrand Z	11/01	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21 **Physician** Edward Severine Farr 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 X M 2 □ F Months Days Hours 81 Director May 19. 1928 Pennsylvania 579-30-0635 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinating must be natified at 1 ☐ Yes 2 X No Director Silver Spring Maruland Montgomery death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3305 Solomons Court 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Heatth and Mental Hygiene. In the filed T is marked other than "natural", or ite iny or other traumatic event, the Medical Examinary or other traumatic event, the Medical Examina 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Assistant Engineer Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ပ Edward John Farr Amelia Leohhler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth a important: if Item 27 Is any Injury or other trains Janet L. Farr - Spouse 3305 Solomons Court, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 10/26/2009 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Liden Re 22. Name and Address of Facility Hines-Rinalti Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer - Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown signed by the signed of the signed of the signed by the signed of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy certificate 2 X No 1 ☐ Yes e Hospital or Attending Physician; 1 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospice 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number . Kou cetche " October 22, 2009

State Registrar

201 E. University Parkway, Baltimore, Maryland 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne T. Kouatchou,

OCT 23 2009

31. Date filed (Month, Day, Year)

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2 2009 GERALDINE EMMA FOLK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** WMHS-Braddock Allegan 'AMPUS 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In rs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🗹 F 76 217-30-1363 Director 7-19-1933 MARYLAND Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director FROSTBURG ALLEGANY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. 11004 BROKEN HEART MINE RD death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes 2 Mo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No WHITE Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BAR OWNER OPERATOR 10 of Health and Mental Hygie item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ALONZO CROWE HELEN WINNER CROWE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other troone. 11004 BROKEN HEART MINE RD FROSTBURG, MD 21532 MIKE FOLK SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FROSTBURG MEM PARK 11-03-2009 FROSTBURG, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. M Sower 4160 moas47 60 W. MAIN ST. FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10maca disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed ne! weld Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗆 No 1 ☐ Yes 1 ☐Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To N☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Sudheer

HEMMU

31. Date filed (Month, Day, Year) 32. Registra s Signature NOV 0 5 2009 >

Kommu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive, Comberland, MD 21502

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

24

	4 60.1	Department of Health and Me	ental Hygiene Reg. No. 2009 35624
Physician	1. Decedent's Name (First, Middle, Last) Howard Mills Green, J	Ir.	Date of Death Sear Sear Sear Sear Sear Sear Sear Sear
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Peninsula Regional Median Central	4b. City, Town, or Location of Death	4c. County of Death •
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 216−16−7689 1) M 2□F 85	/re Months Days Hours Min.	Date of Birth (Month, Day, Year) 11-12-1923 Date of Birth (State or Foreign Country) Maryland
with the Maryland ha or 28a-f show Leantified at	Usual Residence of Decedent	Cess Anne	10d. Inside City Limits 1
and 21215-0036 be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, if a Modrel Examirer must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No If Yes, Give Year or Dates: WWTT	21853 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ring 1 □ Yes 2 ▼ No Specify: Decedent's Usual Occupation	Specify: White 16b Kind of Business/Industry
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or my highly or other traumatic event, it a Modical Examinate. To Be Completed by F	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 none Fa	(Give kind of work done during most of working life. DO NOT use retired) 11TMET	Agriculture
Maryland 2 should be fil n and Mental H is marked ott raumatic even To Be		Miriam Pov	
ite, Ma	Juanita Green/wife 115 20a. Method of Disposition 20b. Place of	Mailing Address (Street and Number or Rural No. 660 South Beckford Avec Disposition (Name of crematory or other place)	., Princess Anne, MD 21853
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	VESTECUTAL 2 LICIETTATION 3 LINETTOVALITOTI STATE		2009 Princess Anne, MD
Physician /Medical	23. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Inmediate Cause (Final disease or condition resulting in death) a	11673 Somerset Ave., or enter the mode of dying, such as cardiac or r	Princess Anne, MD 21853 espiratory arrest, Interval Between Onset and Death
icate be executed transit and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (usease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of c. Due to (or as a consequence of c.		
w requires that the death certificate been signed by the attending physholid be detached for use as the letted by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
hecolds, relatives that has been signed to 2 should be determed by Please by	Part II. Other significant conditions contributing to death but not resulting in the distribution of the distribution of the conditions contributing to death but not resulting in the distribution of the dis	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown
cian: The law requir cian: The law requir ertificate has been si ector, page 2 should I	atrial fibrillation 25. Was case referred to medical examiner?	26. Place of Death (C	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outp. 27. Mann Death 28a. Date of Injury 28b. Tir	ne of ury 28c. Injury at Work? M 1 Yes 2 No	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)
o the Hospital ithin 24 hours the Funeral ompletely filled	29a. Certifier (Check only one) 1	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
To the I within 2 Complet	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type C. Brett Hofmann, M.D. F. 131. Date filed (Month, Day, Year) 32. Registrar's Signature	R.M.C. 100 E. Carro	11 St. Salisbury 21801

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2009 1 - State Registrar 35625 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Edward Grinder October 21, 8:25 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles 13 Fairmont Place INdian Head 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 □ F 218-24-0583 Yrs. **Director** June 20, 1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ir. A folial Example. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 13 Fairmont Place U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 TYes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: Korea White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Conctract Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Clements Grinder Catherine Elizabeth Mattingly 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Nettie Christine Grinder 13 Fairmont Place, Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 24, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial GArdens Waldorf, Maryland 21. Signature of Funeral Service Life see 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Ent a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) as been signed by the a 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33496 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. P.D.Box 2665

State Registrar

DHMH 17 Rev 1/2001

09-08342

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lickey Lee God		State of State of Registrar	Maryland / [Departm <i>Certific</i>			Mental		g. No. 20	09 3562				
Physici	an/	Decedent's Name (First, Middle,Last)	- 11					2. Date of Deat Month October 2	h	3. Time of Death 1806 hrs				
Medical Exami		Rick L. G 4a. Facility Name (if not institution, give str	eet and number)		4b	. City, Town, or L	ocation of Dea		4c. County of Dea					
		924 Bedford Street				Cumberland			Allegany					
Funeral Director		5. Social Security Number 6. Sex		In yrs. last birl	thday)	If Under 1 Year Months Days	If Under 24H Hours N			Birthplace (State or Lansing,				
- Director		234-96-7567 1XM Usual Residence of Decedent	2 F	54	Yrs.			March	19,1956	Country) MI				
any		10a. State 10b. County	10	c. City, Town	or Location	1				10d. Inside City Limits				
S S Maryland 28a-f show	Į.	MD Allegan	у	C	umber				og. Citizen of What Co	1 X Yes 2 No				
or 28a-1	Director	10e. Street and Number				10f. Zip Code	0			ountry?				
with the Maryland ms 23a or 28a-f sho be notified at once.	ral		. Was Decedent Ev	er in U.S.	13. Was	2150: Decedent of Hisp	anic Origin? (Specify Yes or No	USA 14. Race - Am	erican Indian, Black,				
death or iten	Funeral	1 X Never Married 2 Married 1		No		s, specify Cuban,		rto Rican, etc.)	White, etc.					
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0036 within jene.	dmc		1	Se	lf em	ployed 1	hairsty	/list Ime (First, Middle, I	Hairsty	ling				
215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) Lloyd 0. Godby] 1		na L. Jac	,					
	10	19a. Informant's Name/Relationship (Type	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip											
nore, MD 2 ages I and 2 shouls ent of Health and M nt: If item 27 is m			Donna L. Godby/Mother 380 Parkview Drive Keyser, WV 26726 Da. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town											
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 3	Removal from State	crema	itory or othe	er place)	. 1	Nov. 1 2009						
Iltim nit. Pa artmen oortant		4 Donation 5 Other Specify: Potomac Memorial Gardens 2009 Keyser, W 21. Signature of Funeral Service Lick See 22. Name and Address of Facility Smith Funeral Home												
Ba Perr Dep Imi		William Toul 1 85 S. Main Street Keyser, WV 267												
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atheroscleortic cardiovascular disease												
xaminer		Immediate Cause (Final disease or condition resulting in death)	ypertensi to (or as a conseq	ve ath	neroso	cleortic	cardi	ovasculai	disease	Death				
	L	Sequentially list conditions, b												
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a conseq	uence of):										
ed nsit	Exar	events resulting in death) Last Due	to (or as a conseq	uence of):										
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760, cate be physical the burn	/Med	IF FEMALE: 23b. Was decedent pregnant in the	230. If yes, outcome	of pregnancy	/				23d. Date of deliv	•				
Box 6876: death certificate the attending phy ed for use as the le	cian	past 12 months?	Live birth Pregnant at tire		-=	al death 3 [er (Specify)	Ectopic pre	gnancy	Month	Day Year				
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Division of Vital Records, P.O. B ral or Attending Physician: The law requires that the drs after death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached i	þ	Part II. Other significant conditions co Smoking, chronic	-				iven in Part I.		_	robably 4 Unknown				
ords, v require s been si should b	Completed	ketoacidosis			_			24a. Was	an 24b. Were	autopsy findings available to completion of cause of				
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f Vit Physic er this c	မ	1 Yes 2 No 27. Manner of Death	oital: 1 Inpatient		Outpatient . Time of In	<u> </u>	Other ₄ Nury at Work?	rsing Home 5	Residence 6 🗸 Ot how injury occurred	her: Scene				
on of ' anding Ph tth. r: After t	tion:	1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	ar)	. Time or m		es 2 No	200. 2000.100	non inquity coodinate					
Division pital or Attent ours after death teral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home,	farm, street	, factory, office b	uilding, etc.	28f. Location (Rural Route Number, City				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: Of	the basis of exami	knowledge, de ination and/or	eath occurr investigation	ed at the time, da on, in my opinion	ite and place, , death occurr	and due to the cau ed at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)				
To To com	Mec	29b. Signature and title of certifier	d-manner stated.	1/130	Q(E)	29c. Licens			29d. Date signed (
		Outo Sate	~ {/eed		-0-	0.C.1	M.E.		October 28, 20	009				
		30. Name and address of person who con Victor Weedn MD JD Assi	pleted cause of destant Medical i			enn Street, B	altimore. N	MD 21201						
s	tate	31. Date filed (Month, Day, Year)	32. Regist ar's		-	0								
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	-	For State Registrar	State of Ma	ryland /	Depar Certi	tment of H <i>ficate of L</i>	lealth and N Death	Mental Hy	giene _{Reg. No.} 2 (009	35627
Physicia	ın	1. Decedent's Name (First, Middle, Las Joyce A.	Hop					2. Date of Dea	ath Day	Year 2009	3. Time of Death
/Medica		4a. Facility Name (If not institution, give		her			Location of Death		4c. Count	y of Death	
Funeral Director		220-00-0500		(In yrs. last b 47		f Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da 08/27/	th ly, Year) 1962	Coun	place (State or Foreign htry) yland
Maryland f show	or	Usual Residence of Decedent 10a. State Maryland Wicomic	co	10c. City, Tov	wn or Locat	tion				1	0d. Inside City Limits 1 ☐ Yes 2 No
r 28a-	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	ntry?
th with	ョ	805 Briarcliff Ro	oad			2180	4		USA		
	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 K N If Yes, Give		If Y	s Decedent of Hi es, specify Cuba]Yes 2 ☐ (No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ice - Americ ack, White, o	
nin 72 hour in "natural" Wedlen Ex	Completed t	15. Decedent's Ed (Specify only highest gra	Year or Dates: ucation de completed) College (1-4or 5-		a. Deceder (Give kir life. DO	nt's Usual Occup ad of work done o NOT use retired	ation during most of work)	king	16b. Kind of E		
d with giene giene er tha	E O	12	— — —		anufa	cturing	employee		plas	tic	
d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam				
y ca	၉	Everett J. Harr					_	et A. He			
Tand 2 should be filed within 1 and 2 should be filed within Health and Mental Hygiene. Em 27 is marked other than ther traumatic event, It's Manager 1 and		19a. Informant's Name/Relationship (Teresa Wheatley/			805 1	Briarcli	ff Rd.,	Salisbu	ry, MD	21804	,
Darmit, Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		1 -	n Cen	on (Name of fory or other plac netery	10/2	Date 23/09		on, ME)
permit. Depart Import any Inj		21. Signature of Funeral Service Licen	Blan	el	²² H	Name and Address Olloway Ol Snow	Funeral Hill Rd.	Home Pro	ofessio oury, M	nal A: D 2180	ssociation 04
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each line	the death. Do	o not enter	the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. MAZICA Due to (or as a			LUNG	CAR	2/2000	4		Onset and Death
	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b Due to (or as a	consequence	e of):						
	al Examiner	resulting in death) Last	C. Due to (or as a	consequence	e of):						
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Physician: The law requires that the death certificate this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 🗖 Fetal dea		ctopic pregnancy other (specify)	ý		- 1	ate of deliver	ery Day Year
uires that the signed by Id be detacted	2	Part II. Other significant conditions o	ontributing to death bu	t not resulting	in the unde	erlying cause give	en in Part I.		obacco use coi		he cause of death?
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, (Specify)	farm, stree		Yes Z INO	28f. Location (City or To		nber or Rura	al Route Number,
e Hospita 24 hours e Funeral letely fille	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination a							
Vithir Comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
The same						L Do	005841	0	10/	20/	09
1 10		30. Name and address of person who	& P.O.	BOX 1	(Type, Pri	SAu	> BUN	y w	02	180	2
Stat Registra		31. Date filed (Month, Day, Year) OCT 2 2		r's Signature	9. S.	arth		/			
		OUI ME	- JUV		3 9						

18. Mother's Name (First, Middle, Maiden Surname) Shughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10619 Log Cabin Road, Denton, Maryland 20c. Location - City or Town, State Denton, Maryland 22. Name and Address of Facility Moore Funeral Home 12 South Second Street, Denton, Maryland 2167 Approximate Interval Between Onset and Death rupture of membrane 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe Street, Baltimore, Md 21287 HISCOL 31. Date filed (Month, Day, Year) egistrar's Signatur **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Yea

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

Maryland

Caucasian

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland / Department of Health and Mental Hygiene 23aPt II, 27,28a-I per me, 2906,08/20/2010dnb

Certificate of Death

Reg. No. State Registrar 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:11 A.M Kenneth F. Huff 10 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Sinai Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 1 2 M 2 - F Days Hours o*\$\partition 2*\text{8}7\text{1}\text{9\text{3}}5 579**-**74-4900 Washington, D.C 54 Yrs **Director** Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 Pall Mall Road 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth Huff, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1243 Jackson St. N.E. #4 Washington DC Gordy Anomnachi/Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington Nat. Cem. 1 🗌 Burial 2 🖾 Cremation 3 🔲 Removal from State 10/27/2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. . Signature of Funeral Service Licensee 4217 9th St. N.W. Washington, D.C. Marsh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deep detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fetopic pregnancy in the past 12 months? Pregnant
Unknown 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hip Fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2XXNo Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 10 Other: 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury **Fourth**, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at After Found: a Unknown 1 Accident 5 Pending Probable fall 1 ☐ Yes 2X No 08/18/2009 Investigation within 24 hours after death

To the Funeral Director; A

completed filled in by the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4601 Pall Mall Rd. 1timore, MD 4 Homicide determined Rehab Center Baltimore, Hospital Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar comm

21228

30. Name and address of person who completed cause of death (Item 26a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Middle, Last) 13,2009

4b. City, Town, or Location of Death

County of Death

1 - For State Registrar 1. Dece **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner **Funeral** Director 10a. State 28a-f show Director Hilton Hous Funeral Baltimore, Maryland 21215-0036

Physician /Medical Examiner The law requires that the death certificate be executed burial-transit and Box 68760, attending physician for use as the buria signed by the atte P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Registrar

Hospital of Baltimore altimore City Baltimore Birthplace (State or Foreign 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 Ses 2 □ No Umore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT, use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) SISter 6 Sopling District Heights MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 10-22-09 RIVERdate, 140 4 □ Doffation 5 □ Other (Specify) 21. Signature of Funer I bervice Lic Place Camp Springs Mo 22. Name and Address of Facility AUCH Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 days Due to (or as a consequence of): Congestive heart failure Sequentially list conditions, I cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis

Due to (or as a consequence of): days Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic obstructive pulmonary disea Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KES-000 October 13 , 2009 30. Name and address of perso wbo completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Jason J.C. MD 31. Date filed (Month, Day, Registrar's Signat State OCT 2 3 2009

			State of Maryland / Department of Health and M 1 - State Registrar Ameno#'s23e.29c.PerPhys.PCC10-23-09Certificate of Death		ene 2009	35631
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
1000	/Medic	al	Roy Lee Jordan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	October	19,2009 4c. County of Deat	4:40 P. M
	Examin	er	4612 Zion Street Capitol Heigh	ghts	Prince Ge	
	Funeral Director		5. Social Security Number 579-16-4724 6. Sex 1 ☑ M 2 □ F 7. Age (In yrs. last birthday) 87 Yrs. 1 ☐ Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 05/27/19	9. Birt Yea <i>r</i>) 9. Birt Co Emp	nplace (State or Foreign untry) Oria, Va.
	fand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mary la-f sh	ctor	Md. P.G. Capitol Heights			Yes 2 □ No
	ith the	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	eath v	Funeral	4612 Zion Street 20743 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spi	ocify Vas or No.	U.S.A.	rican Indian
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Mesteal Exeminer must be notified at		11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: Specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify: 1	Rican, etc.)	Black, White	
15-(n 72 h "natu edical	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of worki	ng 1	6b. Kind of Business/l	ndustry
212	withir diene.	omo	8th College (1-4or 5+) National College (1-4or 5+) Mail Truck Driver	1	J.S. Posta	l Service
nd	be filed ital Hyg id other event, i	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	aiden Surname)	_
ryla	12 should be hand Menta hand Menta hand Menta fis marked traumatic events	မ		Lee Fer		
Mai	12s thar 7 is trau		19a. Informant's Name/Relationship (Type. Print) Ruby L. Jordan/Wife 19b. Mailing Address (Street and Number or Rural 4612 Zion Street, Capit		•	ip Code) 0 743
ore,	es 1 and 2 e of Health a of Item 27 is rother trau		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio		0c. Location - City or	Town, State
Ε̈́Ε	Page tment tant: It jury o		1XX Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Nat'l. Mem. Park 10	0/27/09	Laurel, Mar	ryland
Bal	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee 12. Name and Address of Facility 12. Name and Address of Facility 14. S. Washington 14925 Burroughs Ave.	n & Sons ,N.E.,Was	Co.,Inc. shington,D	.C.20019
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Cardiopulmonary Arrest Due to (or as a consequence of):			
	Examiner		The same that the same			
	be is	iner	Sequentially list conditions, if any leading to immediate cause. Entire Underlying Cause (Disease or Injury that initiated events C. Hypertension			
•	executions and aftrans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. <u>Hypertension</u> Due to (or as a consequence of):			
68760,	lificate be executed g physician and as the burial-transit	edical	d			
			IF FEMALE:			
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as to	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year
	ss that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w require s been sig should b	ted		1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown
Vital Records,	iclan: The law i	Completed	25. Was case referred to medical 26. Place of Death	-	ed? prior to death? ANo 1 □ Yes	topsy findings available ompletion of cause of
<u> </u>	Physician: this certific al director,	To Be	examiner?		nce 6 □ Other <i>(Spec</i>	
Division of	ing l	L:io		28d. Describe hov		***************************************
Sio	Attendideath.	icati	2 Accident investigation M 1 Yes 2 No	29f Location (Other	- A	- I Banda Museban
<u>></u>	al or Attendates after death	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	eet and Number or Ru State)	rai Houte Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within 2 To the comple	Ĭ	29b. Signature and title of certifier 29c. License number 000436		d. Date signed (Month	
	,		Mong Comment of Mon 1903		October 22,	2009
2	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Wilson, M.D. 106 Irving St., N.W., # 315S, Wash	inatas 5	C 20010	
Ĭ	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 3 2009 Consult of the filed (Month, Day, Year) OCT 2 3 2009 Consult of the filed (Month, Day, Year) OCT 2 3 2009 Consult of the filed (Month, Day, Year) OCT 2 3 2009 Consult of the filed (Month, Day, Year)	ington, D	.c. 20010	

State of Maryland / Department of Health and Mental Hygier 0 35632 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Althea Marjorie Smith James 17, 2009 October 0 1:45 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3409 Dodge Park Road; Apt. 102 Prince Georges Landover If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Days Hours Min 60 Yrs. April 25,1949 Washington, D.C. Director 579-64-9891 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, the Modical Exemples at 1 X Yes 2 □ No Maryland Prince Georges Landover Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "---- any injury or other treumair." 3409 Dodge Park Road; Apt. 102 20785 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Woodside Nursing Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Martha Brown Willie Lee Smith 19a. Informant's Name/Relationship (Type, Print)
Bernard Herman James (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 Pamela Antoinette Jones (Daughter) 3409 Dodge Park Road; Apt. 102; Landover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct.27,2009 1 X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Heritage Memorial Cemetery Waldorf, Maryland Signature (Funeral Servi 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BARMS+ CONCER **Physician** 2 wer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, a try, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran death certificate be exec Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? Month 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforr 1 ☐ Yes 2 ☐ No 2X No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X,No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 180 October 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road; Suite 300 Stanley Watkins, Jr.; M.D. Annapolis, Maryland 32. Reg State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Robert Lee King October 21, 2009 /Medical 2:15 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 577–46–2714 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, 6 Sev 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Washington, DC Months Days Min. 11 M 2□ F ^Y1934 75 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes X X X lo Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4900 Wilson Court 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2XX Married 1 ☐ Yes 2XXNo Specify. ò 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Produce Clerk 12 years Giant Foods Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elton Leonard King ဥ Margaret Eloise Clemmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. King / Wife 4900 Wilson Court Camp Springs, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 ☐ Burial 2 KD remation 3 ☐ Removal from State Kalas Crematory 10/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FATAL CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 □Yes 2XXX No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X XNo Certification: To 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

the Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. certificate has After this death.

the burial-tran the attending physician ned for use as the burial cate has been signed by page 2 should be detach funeral within 24 hours after death To the Funeral Director: filled in by

28a-f shov

items 23a

6

'natural",

d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n

. Pages 1 and 2 should by trient of Health and Ments tant: If Item 27 is marked

Item 27

72 hours after

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

31. Date filed (Month, Day, Year OCT 2 3 2009

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifie

6 ☐ Could not be

determined

Wendell Pierson, M.D. 7503 Surratts Rd., Clinton, MD 32. Registr

30. Name and address of person was completed cause of death (Item 23a) (Type, Print)

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

completely

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainler as stated.

29c. License number

D 53209

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10-21-2009

29d. Date signed (Month, Day, Year)

			For State Registrar		rtificate of Death	Reg. No. 0 0 9
ľ	Physicia	an	1. Decedent's Name (First, Middle, Last) Young Shir	n Kim		2. Date of Death Month Day Year October 21, 2009
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	t Ruit	4b. City, Town, or Location of Death	October 21, 2009 4c. County of Death
300		<u>.</u>	Forest Glen Nursing & Rehab 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Silver Sprin	8. Date of Birth 9. Birth
L	Funeral Director		220-78-6734 1□M 2KDF	83 Yrs.	Months Days Hours Min.	(Month, Day, Year) Cot 11/05/1925
	yland now at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		
	ne Mar 8a-f sl	Director	Maryland Montgomery		Gaithersbur	
	with the a or 2 the no	Dir	10e. Street and Number 21005 Brooke Knolls Road	d	10f. Zip Code 20882	10g. Citizen of What Co.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1	ver in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	
Baltimore, Maryland 21215-0036	nin 72 ho in "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	
212	ed with	Com	12		Cashier	7-11 S
land	uld be file fental Hy rked oth tlc even	To Be	17. Father's Name (First, Middle, Last) **Dong-IL Oh**		18. Mother's Nam	e (First, Middle, Maiden Surname) Jin-Wha Lee
lary	2 short and N ls ma		19a. Informant's Name/Relationship (Type. Print)		-	ral Route Number, City or Town, State, Z
e,	1 and Health em 27		Don Kim - Son 20a. Method of Disposition			d., Gaithersburg, M Date 20c. Location - City or
timor	permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Norbeck N	Memorial Park 10/2	
Bai	permit Depar Impor any In once.		21. Signature of Funeral Service Licensee			nes-Rinaldi Funeral 2 Ave., Silver Spri
68760,	Company of the private of the privat	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): consequence of): consequence of):		
.O. Box 6		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	23d. Date of deli Month
<u>s,</u> Р.	res that t igned by be detar	by	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to
Record	The lar ate has page 2	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 1 2 No 1 ☐ Yes
Division or Vital Records, P.	anding Phy ath. or: After this ne funeral d	Certification: To Be (27. Manner of Death 1 🖪 Natural 5 Pending (Month, Day) 2 Accident investigation	Year) Injury y - At home, farm, st	ont 3 DOA Other: 4 🛛 Nursing House Work? M 1 Yes 2 No	th (Check only one) ome 5 Residence 6 Other (Special Residence of the Resi
ō	ospital or hours afte uneral Dir		29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of	f my knowledge, dea		, and due to the cause(s) and manner as
	To the Hospital or Atte within 24 hours after de To the Funeral Directe completely filled in by the	Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of terms.	ed.	29c. License number D52261 Print)	29d. Date signed (Month
			Alan R. Segal, M.D., 151/7 H	ugo Circl	e, Silver Spring,	marykana 20906

Montgomery Birthplace (State or Foreign Country) Korea 10d. Inside City Limits 1 □Yes 2X No zen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Asian nd of Business/Industry 7-11 Store Surname) r Town, State, Zip Code) burg, MD 20882 cation - City or Town, State lney, Maryland Funeral Home, Inc. er Spring, MD20904 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day use contribute to the cause of death? □ No 3 □ Probably 4 ဳ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 6 ☐Other (Specify) ry occurred d Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year) tober 21, 2009

35634

3. Time of Death

2:30 рм

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35635 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19, 2009 **Physician** October 7:40 P M Amiel Bisphane Lucas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital Olney 8. Date of Birth (Month, Day, Jan 27, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2 □ F Hours Min. 214-80-8049 1962 MD Director 47 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanting and 1 □Yes 2 No Director MD Prince George's Adelphi the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20783 1830 Metzerott Road USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Nursery Worker Tree Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amiel Franklin Lucas Vivian Joy Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lan Lucas/wife 1830 Metzerott Road Adelphi, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Final Journey Crematory 10/22/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License, Going Home Cremation Service P.O. Box 784 Beverly I. Heckrotte, P.A. Clarksville MD 21029
of enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a HEAD AND NECK SQUAMOUS CELL CARCINOMA **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or sele consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-trans and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 1 ☐ Yes 2 ☐ No spital or Attending Physiclan: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59418 ASQUERME, MA OCTOBER 21,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADEWUNINI 18101 PRINCE PHILIP DRIVE CLNEY MD 20832 CLUYEMISI M.D.

DHMH 17 Rev 1/2001

State

Registrar

egistrar's Signature

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND#23e, 24a, 25, 26, 27, 29, 30 per Dr. 10/23/09, BW), MOD

1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 0 9 35636 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October 13,2009 **Physician** 11:22 РМ Reid Stephen Luke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/14/1923 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 X M 2 □ F 256-32-4111 86 Georgia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Events in a multiple any once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Hyattsville **Funeral Director** 1K Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5017 56th Place 20781 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 Nol 943-14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1946 1 ☐ Yes 2 🖾 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Civil Servant District Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Luke Sr. Celia E. Fuller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12714 Quarterhorse Drive Bowie, MD 20720 Winston Luke / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/22/2009 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funefal Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to the claim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ORSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive HEOPHUS Cheverly, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State act 23 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^D3^y1 20^o6^b9 MARY EMILY LYNCH OCTOBER 6:05 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Nursing & Rehab Chestertown Kent 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗗 F 88 215-38-1701 Director 1921 Sept 8 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Experience, use the rediffed at Director 1 XYes 2 No MD Kent Chestertown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 72 hours after death with 847 High St. 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2▼ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White 2 Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Small Engine & Elementary/Secondary (0-12) College (1-4or 5+) 11 Owner - Operator Radiator Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry F. Willis Emma Alderson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traun Patricia Morris granddaughter 1015 Twin Court Chestertown, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Kent Cremation 11/2/09 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Galena Funeral 118 West Cross Home of Stephen St. Galena, MD. Schaech 35 L 216 M00510 23a. ntx Enter the disease, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumory disease or condition resulting in déath) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions ributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi nner stated the 29c, License number 0060501 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Michael E. Peimer, 122 Speer Rd. Chestertown, MD. M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physicia /Medic Examin pop 1012112009 Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, the "Madical Examination and any injury or other traumatic event, the "Madical Examination and once." 6 1305 Baltimore, Maryland 21215-0036 02/10/1955 DOB Physician /Medical 222-40-0851 Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sue A. Meadows Sta Registra DHMH 17 Rev 1/2001

1 - For State Registrar	State of Mary		artment of H rtificate of D						
1. Decedent's Name (First, Middle, Las	;t)					Reg. I Date of Death	201) 9 3. Tale 5	5atil 3
SUE ANN I	MEADOWS				O.C.	Month I	Day Ye 200	11205	М
4a. Facility Name (If not institution, give			4b. City, Town, or	Location of			1c. County of D		
ATLANTIC GENERAL I	HOSPITAL		BERLIN				WORCE	ESTER	
5. Social Security Number 6. Social Security Number 222–40–0851	ex 7. Age (In 54	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, Yea RUARY 10	9.	Birthplace (State of Country) DELAWARE	
Usual Residence of Decedent 10a, State 10b, County	100	Ch. T-							
		City, Town or Lo						10d. Inside Ci	
MARYLAND WORCEST	LEK	OCEAN CI	10f. Zip Code				0111	1 ☐ Yes	ZK INO
12/07 DELLA VICE	A LANE #26		,			10g.	Citizen of What	Country?	
13487 BELLA VISTA	12. Was Decedent Ever	inUS 13	21842	nanic Ori	igin? (Specifi	Ves or No.	USA	American Indian,	
MARYLAND WORCEST 10e. Street and Number 13487 BELLA VISTA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12) 12	Armed Forces? 1 ☐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □Yes 2 ሺ No	Specify:		an, etc.)		/hite, etc.	
15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	tion	of of supplishing	16b.	Kind of Busine	ess/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	uning mos	st or working				
12			HOMEMAKER				OWN HOM	1E	
17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (F	rst, Middle, Maid	en Surname)		
JOHN H. MART					JANET		HILLIPS		
19a. Informant's Name/Relationship (7			ng Address (Street a						
JAMES W. MEADOWS/H			BELLA VI	STA I			N CITY,	MD 2184	2
20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □		Ob. Place of Dispo cemetery, crei	osition <i>(Name of</i> matory or other place)	Date	20c.	Location - City	or Town, State	
4 □ Donation 5 □ Other (Specify		REMATORY	OF DELMA	RVA O	CT.23,	2009 DE	LMAR, D	ELAWARE	
21. Signature of Funeral Service Licens	and		2. Name and Addres		•	, SELBYV	ILLE, D	DE 19975	
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.	death. Do not ent	ter the mode of dying		cardiac or re	spiratory arrest,		Approximate Interval Bet Onset and D	ween
resulting in death)	Due to (or as a cor	1							
Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	nsequence of):							
resulting in death) Last	Due to (or as a con	sequence of):		-					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ i 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>				23d. Date of Month		/ear
Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	n in Part I	i.			e to the cause of d Probably 4 ☐ t	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						24a. Was an autopsy performer 1 🗀 Yes 2 🔊	prior deat	autopsy findings a to completion of ca h? Yes 2 \Box	available ause of
25. Was case referred to medical examiner?				26. Place	e of Death (C	heck only one)			
1 Yes 2 No	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA Othe	r: 4 □ Nu	ursing Home	5 Residence	6 □Other (5	Specify)	
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	Work'	at es 2□	ľ	Describe how in	jury occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str pecify)	eet, factory, office		28f.	Location (Street City or Town, St.	and Number of	r Rural Route Num	ber,
29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my op	e, date ar inion, dea	nd place, and ath occurred	due to the cause at the time, date a	e(s) and manne and place, and	er as stated. due to the cause(s)
29b. Signature and title of certifier) [,]		29c. License		0		1 1	onth, Day, Year)	
30. Name and address of person who c	ompleted cause of death ((Item 23a) (Type, 3 H = d	Print) Uth Way	Dn'u	e 13.	erlin	MD	21811	
31. Date filed (Month, Day, Year) OCT 2 2 20	ACH 973 32. Degistrar's S	ignature A.	arke						

			1 - State of Maryland / E	Department of H Certificate of I			ene	0 25620
Į,		!	Decedent's Name (First, Middle, Last)			2. Date of Deatl	200	3. Time of Death
	Physicia /Medic		ROBERT HAROLD MOORE			OCTOBER	19, 2009	6:45 A ^M
	Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of Deat	
46		-3	3806 Hamilton Street, #302 5. Social Security Number 6. Sex 7. Age (In yrs. last bir		sville	8. Date of Birth	Prince (George's
	Funeral Director		10M N OFF	Yrs. Months Days	Hours Min.	(Month, Day, April 4	Year) Co	nplace (State or Poreign buntry)
_ 266	day of		Usual Residence of Decedent			APLIL 4	, 1933 Fai	isy, Ki
	how lat	_	10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
	e Ma 8a-f s atifiec	Director		sville				1 X Yes 2 □ No
	with th	Dire	10e. Street and Number 3806 Hamilton Street, #302	10f. Zip Code	781	10	Og. Citizen of What Co USA	ountry'?
	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.			ecify Yes or No-	14. Race - Ame	rican Indian,
(0	ifter d r iten siner	Fun	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give	13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Whit	e, etc.
93	ral', o	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: KOREAN	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
5-0	72 h "natu dical	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	king	16b. Kind of Business/	Industry
121	within	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	telligence Oper			USAF	
d 2	Hygie Hygie ther		17. Father's Name (First, Middle, Last)	Jerrigerice open		e (First, Middle, N	faiden Surname)	
an	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be	Rex Moore		Georgia	Fee		
ary	ges 1 and 2 should it of Health and Men If Item 27 is marke or other traumatic	_	19a. Informant's Name/Relationship (Type. Print) 19b	b. Mailing Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)
Σ	and 2 ealth a n 27 Is		·	.0. Box 532,				
ore	Jes 1 of He		1 Burial 2 Cremation 3 Bemoval from State	of Disposition (Name of ery, crematory or other place	ce)		20c. Location - City or	
Baltimore, Maryland 21215-0036	t. Pag tmen tant: njury		4 Donation 5 Dotter (openly)	olitan Cremato		1/2009 A	lexandria,	virginia
Bal	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trae		21. Signature of Funeral Service Licensee	22. Name and Addre		me, P.A.		imore Avenue le, MD 20781
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG	G CANCER				Onset and Death
ď	/Medical Examiner		Due to (or as a consequence	of):				
	- 4	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate caus. Effect underlying Cause (Disease or injury that initiated events					
oʻ	exec an an irial-tr	Exa	resulting in death) Last	of):				
8760,	cate be executed physician and the burial-transit	dical	d					
9	ertific	Med	IF FEMALE: 23c. If yes, outcome pf pregnancy					
Вох	leath certific attending p I for use as	Physician/Me	in the past 12 months?	h 3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of de Month	livery Day Year
P.O.	that the de ed by the detached	ysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown					
	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	by Pł	Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w require been sig should b	ed b				1 □ Ye	es 2□No 3□P	robably 4 🛣 Unknown
900	e law re has be	Completed				24a. Was ar		utopsy findings available completion of cause of
<u> </u>	The ate h	Com				perforr 1□ Yes 2	ned? death? 2 ANo 1 ☐ Yes	2 □ No
/ita	clan:	Be	25. Was case referred to medical examiner?	104		th (Check only on	e)	
Division or Vital Records,	Physician: The la r this certificate has ral director, page 2	10 10	1 Yes 2 WO 1 Inpatient 2 ER/OL	·	4 □ Nursing H		nce 6 □Other (Spe	cify)
no	ding I h. After funer	tion		Injury Wor	rk? Yes 2∐No	Zod. Describe no	w injury occurred	
is.	or Attending after death. Director: After in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)	arm, street, factory, office			reet and Number or R	ural Route Number,
á	al or s after al Dire	Certification:	4 normalise building, etc. (Specify)			City or Town	i, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Check only one) Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the ti nd/or investigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. Licens	se number	2	9d. Date signed (Moni	th, Day, Year)
			* Kalunto Clackness	#332	55	0	CTOBER 19,	2009
1	- 6H		30. Name and address of person who completed cause of death (Item 23a)		יאג היון סקי	MACHITMO	יייטאי ארי ארי	22/600
	711		KAREN ANN BLACKSTONE, M.D., VAMC,		IKEEL NW,	WASHING	TUN, DU ZU4	122/000
15	Sta Registi		31. Date filed (Month, Day, Year) 32. Registry's Sign ture OCT 2 3 2009 Server A.					

DHMH 17 Rev 1/2001

				epartment of Health and N Certificate of Death	Mental Hygier	ne No. 2009	35640
*	Physici /Medic		Justin Michael	McJilton	2. Date of Death Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
7	Funeral Director		219-27-0081 23	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Feb. 12,	r) Country	
	vfaryland -f show ed at	tor	Usual Residence of Decedent 10a. State			10	d. Inside City Limits
	or 28a e notifi	Director	Maryland Caroline Dent	10f. Zip-Code	10g. (Citizen of What Countr	y?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	8108 Haven Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Never Married 2 Married 3 Widowed 4 Divorced 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, Give Year or Dates:	21629 13. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No-	14. Race - America Black, White, et	C.
21215-0036	thin 72 hour e. an "natural' Medicai Ex	Completed k	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		Kind of Business/Indi	asian
	ould be filed withi Mental Hygiene. arked other than atic event, the M		12 HS grad 5 17. Father's Name (First, Middle, Last)	Student 18. Mother's Nam	ne (First, Middle, Maid	Educati den Surname)	on
Maryland	buld be Mental arked c	To Be	Joseph Marvin McJilt			Brechbill	
	27 mg and			Mailing Address (Street and Number or Ru			
more,	Pages 1 and 2 nent of Health ort: If item 27 iny or other tra		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of cemetery	Disposition (Name of r, crematory or other place)	Date 20c.	Location - City or Tow	n, State
altim	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses	91	• • • • • • • • • • • • • • • • • • • •	enton, Mary il Home, P.	
m •	permi Depar Impor any ir		232 Sard 1 Poter the disable or complications that caused the death. Do no	12 South Second Sta	reet, Dent	on, Maryla	
	Physician	Y 1	23a. Part 1. Inter the disease or complications that caused the death. Do no shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition 2 × SG NOV)		or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence or				
	- H	iner	Sequentially list conditions, if any heading to firm and the cause. Enter Underlying				
	be executed sician and burial-fransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
760,	ate be e hysician the buri	dical	a Aplestic	gremia			
O. Box 68	e death certificate be executed the attending physician and thed for use as the burial-transi	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnancy Under (specify)	.!	23d. Date of deliver Month	y Day Year .
Ο.	The law requires that the derete has been signed by the a page 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
Division of Vital Records,	The lar	Completed	•		24a. Was an autopsy performed 1 Tyes 2	prior to con death?	sy findings available inpletion of cause of 2 No
Vita	ysician: The sectificate director, pa	Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Out	Other	h (Check only one)	6 ☐ Other (Specify)	
ion of	or Attending Physician: after death. Director: After this certifica i in by the funeral director,	ation: To	27. Manner of Donth 28a. Date of Injury 28b. To		28d. Describe how in		
Divis	l or Atter after dea Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	t and Number or Rural ate)	Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled	edical C	29a. Certifier (check only one) Sertifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) Oc	tulars 10,	6009
			Aleigail Lenhart MD	600	North Wolfe	St, Baltimore	e, MD, 21287
	Sta Registr		OCT 14 2009	park			

DHMH 17 Rev 1/2001

165

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year MAUZY DORIS 1519 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 6 F Director 213**-**24-6424 2-19-1928 MARYLAND Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, it w Modical Experimer must be notified 1 ☐ Yes 2 No Director MD ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13301 WINCHESTER RD SW LOT J 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. 2 Specify 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 SEAMSTRESS SEWING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH HAUPT ပ ELLEN RANKIN HAUPT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a DONNA KETTERMAN DAUGHTER 17721 KETTERMANS LANE RAWLINGS, MD 21557 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date of Department of Important: If it any injury or o 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 10-29-2009 CUMBERLAND, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOWERS FUNERAL HOME, P.A. Sowe 3 FROSTBURG, MD 21532 4100 MO0547. 60 W. MAIN ST., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mester lene is ham Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events Dunito (ur as a consequence of): Examiner certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Vear 5 ☐ Other (specify) cate has been signed by the page 2 should be detached ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has 24a Was an 1 ☐ Yes 2 MNo Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? al or Attending F s after death.
al Director: After ed in by the funer. 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Y ABMEAUR KHARAT 22 S GREENE Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

STREET RALDMORE, MO

6328

29d. Date signed (Month, Day, Year)

28

29c. License number

172 024

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:10 AM **Physician** Anne 2009 OCT /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Branch Rippling toward If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Apr 3, 1913 6. Sex 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Min 1 □ M 2 🔀 F Months Days Hours Germany 96 Apr 050-01-9045 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina 1. ust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 XYes 2 No Fairfield Darien CI10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 06820 67 Dubois Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ş 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Buttner Frances Schmauser ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzanne Baldino/daughter 8237 Rippling Branch Rd. Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/22/09 Woodbine, MD Final Journey Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Met astatic Carcinoma Some inknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Citis 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Yes 2 egeneration certificate ar 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Daughter= Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 □ 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death. The Funeral Director: A pletely filled in by the death 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

npletely within 2

Medical

29a Certifier

29b. Signature and title of ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRIUP

gistrar's Signature

32. B

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R0936A3

29d. Date signed (Month, Day, Year)

Van Ousen Rd #130 Laurel MO 2010)

		For State	Pleas				/ Depa		Ensure A dealth and N		ygien	e		05610
		Registrar 1. Decedent's Nam	ne (First, Middle,	Last)			Cer	uncale or i	Dealli	2. Date of D	Reg. Neeath	۰۷ ا	09	35643 3. Time of Death
	ician dical	John Ho	ward N	elson						Octobe		1, 20		6:40 A M
Exar	niner	4a. Facility Name (i		give street and nu	mber)			4b. City, Town, or Bethesda	r Location of Death 3		1		of Death mery	
Funer Direct		5. Social Security N 427–36–6	Number	5. Sex 1 🔀 M 2 🗆 F	7. Ag	e (In yrs. las	Vva	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, I	irth Day, Year	929	9. Birthi Coul Alab	
land ow	e	Usual Residence of 10a. State	f Decedent 10b. County	-		10c. City,	Town or Loc	cation					1	10d. Inside City Limits
e Mary Ba-f sh	ctor	MD	Montgo	mery		Bethe	sda							1 ☐ Yes 2 X No
with the	I Dire	10e. Street and Nu						10f. Zip Code 20817			USA	itizen of V	Vhat Coul	atry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event.	y Funeral Director	11. Marital Status 1 Never Marr	ried 2 <mark>½</mark> Marrie	I If Vac Gi	orces?	No	1	Vas Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Ricen, etc.)	10-	Blac	e - Americk, White,	
2 hour	ted t		15. Decedent's	Education	ales.	1951-5	16a, Deced	lent's Usual Occup	eation	kina	16b.		usiness/In	
within 7 iene.	Be Completed by	Elementary/Seco		College (1-4or 5	i+)	Journ.		during most of worl d)	ung	Net	wspar	er	
e filed at Hygi	Be C	17. Father's Name		ast)					18. Mother's Nam		e, <i>Maid</i> e			
hould the marked matic	2	Howard A					10h Mailin	a Address (Street	Barbara and Number or Ru			or Town	State Zii	n Code)
alth an		Barbara i			vif∈	e			rt Bethes				otato, 24	
Pages 1 annent of He	.		<u> </u>	3 □ Removal from ecify)	State			sition (Name of natory or other place rney Crei	natory 10	Date /23/09			City or To	own, State
bermit. Departr mports uny Inju	Succe	21. Signature of Fu	uneral/Service L	icensee		1104.0	G G	ing nome	ckematic	n Serv	ice	P.O.	Box	784
Physicia	an -	23a. Part 1. Enter to shock, or head immediate Cause disease or condition resulting in death)	art failure. List o (Final on	nly one cause on e	each lir	MO12 the death. ne. tic Ca	Do not ente		ng, such as cardiac			al KS	/1116	Approximate interval Between Onset and Death
/Medic Examin				Due to	(or es	a conseque	ence of):							
uted I nsit	Examiner	Sequentially list co if eny, leading to in cause. Enter Under Cause (Disease or that initiated events	onditions, nmediate erlying r injury	Due to	(or as	a conseque	ence of):							
te be executed /sician and e burial-transit	<u></u>	that initiated events resulting in death)	s Last	c	(or as	a conseque	nce of):		-					
Attending Physician: The law requires that the death certificate r death. ector: After this certificate has been signed by the attending physi by the tuneral director, page 2 should be detached for use as the tental page.	Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2	? months? □No		birth nant a	of pregnand 2 ☐ Fetal d It time of dea	death 3 □	Ectopic pregnanc	у				te of deliv	very Day Year
a law requires that the de has been signed by the e 2 should be detached	/ Phy	9 Unknown				ut not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Dio	I tobacco	use conf	tribute to	the cause of death?
equires sen sigr	ted by									1]Yes	2 🔀 No	3□ Pro	bably 4 Unknown
: The law r cate has be page 2 sh	Ö									24a. Wa eut per 1 □ Yes	opsy formed?		Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
rsician: The s certificate lirector, page	o Be	25. Was cese referexaminer? 1 ☐ Yes 2 🛣		Hospital:	Innatie	ent 2∏F	R/Outnatien	t 3 DOA Oth	26. Place of Dea	•••		6 🗆 O#	ner /Snec	iful
dlng Phy th. : After thi	ition: To	27. Manner of Deal		28a. Date (Mor	of Inju		28b. Time of Injury	28c. Injul Wor	ry at	28d. Describ				<u> </u>
al or Atter after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Flace	e of Inj	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location City or T	(Street a	and Numb te)	per or Rur	ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific	Medical C	29a. Certifier (Check only one)			oasis o	of examination			me, date and place opinion, death occu					
To th	×	29b. Signature end	title of certifier	Tanak	2 m	mo	en h	29c. Licens						, <i>Day, Year)</i> 2009
12		30. Name and add	ress of person v	ho completed cau	se of d	leath (Item	Say (Type, I	Print)			<u> </u>			
	State	Patricia 31. Date filed (Mor				11119 ar's Signatu		ille Pike	e, #G-100	Rockv	ille	, MD	2085	2
	orare.		11111 0 0	2000)		5 /							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 35644 Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 21, 2009 Fabricant 4:15 A M Oliviero /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 1106 Dunoon Road 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth-(Month, Day, Mar 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F New York 070-14-9208 91 1918 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Modical Experience of the rectified Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Dunoon Road 20903 USA by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X If Yes, Give Year or Dates 2 X No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If item 27 is marked other the any injury or other trainment. Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Fabricant Lena Ehrlich ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Oliviero/daughter 1106 Dunoon Road Silver Spring, MD 20903 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 10/22/09 Woodbine, MD 21. Signature of Juneral Service Licensee Going Home Cremation Service MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 ANo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending ours after death.

leral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours a 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D51916 October 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay, M.D. 11119 Rockville Pike, G-100 Rockville, mD 20852 31. Date filed (Month) 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

Soll Bland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0lakunle Ibiola Ogundeji-Akinkoye October 16, 2009 2:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 409 Phelps Street Montgomery Gaithersburg 8. Date of Birth (Month, Day, Ye)
Jan. 22, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year Months Hours 1 □ M 2 🖺 F 216-33-1709 44 Director 1965 Nigeria Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show s 23a or 28a-f shows 1 ☐ Yes 2XXX0 Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 409 Phelps Street 20878 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian r than "natural", or items 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Black Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 than Elementary/Secondary (0-12) College (1-4or 5+) Microbiologist 12 should be filed with and Mental Hygier 7 Is marked other th Medical traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Olafusi Ogundeji Olamojiba Fadayomi ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traunonce. Akin Akinkoye/Husband 409 Phelps Street, Gaithersburg, MD 20878 timore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ¥⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. Gate of Heaven Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service License 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Cervical Cancer vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and stransit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a o 9 ☐ Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown seen si Completed The law 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy certi icate 1 ☐ Yes 2 ☐ No of Vital 1 □ Yes 2 🖼 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1∐Yes 2∑XNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. After Division 1 🖪 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD = 030110 10 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)
Antonio F. Fojo, MD 9000 Rockville Pike, Bethesda, MD 20892 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eleanor Τ. Otley 2009 2:27 P M October 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Olney Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Vear Months Days Hours 1 M 2 X F 577-42-2807 93 Pennsylvania Director Feb. 1,1916 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience is ust by natified at Director MD Montgomery Rockville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 508 Lynch Street United States 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Thomas C. Tilson Mary Josephine Sweeney ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar em 27 is 508 Lynch Street, Rockville, MD 20850 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce. Mary Collins (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mt. Olivet Cemetery 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State October 26, 2009 4 ☐ Donation 5 ☐ Other (Specify) Washington , DC 21. Signature of Funeral Service Lice and Address of Facility
Funeral Home,
Gaithersburg, Deer Park Drive, r Moule ΜĎ 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Year Day Pregnant at time of death 5 Other (specify) detached cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2NN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy μεποτπεςς? 1 □ Yes 2 🛭 No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D OCTOBER 21, 2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 M.D. 18101 PRINCE PHILIP DRIVE OLNEY MD ARUNA PASPULA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 35647 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1255 am Mae Peterman 10 2009 Anna /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Salisbur Hospice at the Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Voarl Min. 1 □ M 2**X** F Months Days Hours 213-22-7941 81 02/28/1928 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exandar traumatic event, If a Medical Exandar traumatic event, If a Medical Exandar event and Issue an 1 ☐ Yes 2 X No Director Wicomico Hebron Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 USA 26213 Porter Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) school cafeteria worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Lillian Houck Leon Rapp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25424 Porter Mill Rd., Hebron, MD 21830 19a. Informant's Name/Relationship (Type. Print) Connie L. Raynor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/09 Hebron, MD Garđens Thorisonal Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee dompson CFSp Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lit Immediate Cause (Final **Physician** TRRI disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No Month Day Year 5 ☐ Other (specify) ned by the Ö 9 Unknown 9 Unknown ď signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 1 ☐ Yes 2 No 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation after death.

Director: Af 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier D 29505 10-17-2009 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR. GALISBURY, MD 21801 31. Date filed (Month, Day, 32. Degistrar's Signature Registrar OCT 21

DHMH 17 Rev 1/2001

ANNA

Determan,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0.00

			For Stat Amedned item Registrar	#7,16a,18,W	CHD, SLU	Jepa Jepa Jepa	tificate of t	Death	nemai r	Reg. No.	2009	35648	
	Physicia	an	1. Decedent's Name (First, Middle, I						2. Date of Month	Death Day	2009	3. Time of Death	
	/Medic	ai	4a. Facility Name (If not institution,	oive street and number)	PUI	$\frac{\langle N \rangle}{ N \rangle}$	ELL 4b. City, Town, or	Location of Death	10	1 <i>4</i> c.	200 7 County of Death	0090H **	
1	Examin	er	A /	MEDICAL CE	NIL		,	SAUSBURY			Nicomico		
	Funeral		5. Social Security Number 6	Sex 7. Age	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 H/s. Hours Min.	8. Date of (Month)	Day, Year)	Coun	lace (State or Foreign try)	
١.,	Director		219-34-2901 Usual Residence of Decedent	70		115.			7-15 4-15-	-1939 -1939	MD		
	yland how		10a. State 10b. County		10c. City, Tov	vn or Loc	ation		1 1		10	Od. Inside City Limits	
	e Mar Ba-f si	ctor	MD Worces	ster	Poco	noke						1 □Yes 2 🛣 No	
	with th	Dire	10e. Street and Number	1000			10f. Zip Code 21851			U.S.	zen of What Coun	try?	
	ns 23	Funeral Director	2242 Groton R	12. Was Decedent E	ever in U.S.	13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or		14. Race - Americ	an Indian,	
٥	i within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Modicel Exeminer must be inclifted at		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	lo	1	Yes, specify Cuba □Yes X □ No	an, Mexican, Puerto Specify:	Rican, etc.		Black, White, e	etc.	
5-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:	T 10						îack		
7		Completed	15. Decedent's (Specify only highest)	grade completed)	197	(Chical)	ent's Usual Occup ind of work done o O NOT use retired	during most of work	ing		nd of Business/Ind cester		
717	filed within 72 Hygiene. vther than "na ent, the Madic	mo:	Elementary/Secondary (0-12) 12	College (1-4or 5-	+) <u>E</u> q	lucat 15 t r	O NOT use retired ional As	st 1 Aide		Sch	nools	_	
and	be filed htal Hygi ed other event,	Be C	17. Father's Name (First, Middle, La					18. Mother's Nam			Surname)		
>		ို	Harvey Bivens		1.0	d. 64-200		Bernice			Tull	Cadal	
Mar			19a. Informant's Name/Relationship Marvin Purnel		1	`	•	and Number or Ru n Rd, Po				_	
ē,	s 1 and of Health item 27 other to		20a. Method of Disposition				ition (Name of atory or other place		Date		cation - City or To		
Ē	Pages nent of ant: If it ury or o		1 → Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1	Zion	Cemete	ery 10-2	24-20	09 Po	comoke	City, MD	
Baltimore,	permit. Pag Departmen Important: any Injury once.	1	a1. Signature of Funeral Service Lie	censee 🗸		22. Be	Name and Addre	ss of Facility 91				_	
	70 = 40 O		23a. Part 1. En er the disease, or co	omplications that caused	the death Dr	Fu	neral H	ome Sa			ID 2180	Approximate	
			shock, or heart failure. List or	nly one cause on each lin	ie.	- 1	l are mode of dyn	ig, sucii as cardiac)\\	ry arrost,		Interval Between Onset and Death	
	Physician /Medical	disease or condition a At Went Clent of Charles											
	Examiner		1 1101 (00100										
40	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	onsequence	of):	*	0					
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98/60	tificate be executed ng physician and as the burial-transit	edical E		d									
			IF FEMALE:							-			
ŘOŘ	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnanc	y			23d. Date of delive Month	ery Day Year	
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 ∟	Other (specify) _	-					
7.	w requires that the dasheen signed by the should be detached	by Ph	Part II. Other significant condition	s contributing to death bu	ut not resulting	in the un	derlying cause giv	en in Part I.	23e. [Did tobacco u	ise contribute to the	ne cause of death?	
rds	equires en sig ould be	ed b								Yes 2[□ No 3 □ Prob	oably 4 ☐ Unknown	
Records ,	law re nas be	Completed							a	Vas an lutopsy	prior to co	psy findings available mpletion of cause of	
		Con							1 □ Y	erformed? es 2 No	death? 1 □ Yes	2 □ No	
Vita	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		S	Oth	26. Place of Dea			0 TOther (0	6.3	
ō	iding Physician: th. After this certifical funeral director, p	n: To	27. Manner of Death	28a. Date of Injur		. Time of	28c. Inju	4 □ Nursing H		ibe how injur	6 ☐ Other (Specil y occurred	<u> </u>	
<u> </u>	ttending Jeath. tor: Aft the fun	atio	1 ☑ Natural 5 ☐ Pending investiga		y, Year)	Injury	M 1 🗆	k? Yes 2□No					
Division of	700>	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, c. (Specify)	farm, stre	et, factory, office			on (Street an Town, State	d Number or Rura)	al Route Number,	
	pital ours a seral C		29a. Certifier 1 Certifying	Physician: To the best of	of my knowled	oe. death	occurred at the ti	me, date and place	and due to	the cause(s) and manner as	stated.	
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Ex	xaminer: On the basis of and manner sta	f examination a	and/or inv	estigation, in my	opinion, death occu	rred at the t	me, date and	d place, and due to	o the cause(s)	
	To the vithin To the comp	Me	29b. Signature and title of certifier	1 mul			29c. Licens			29d. Da	te signed (Month,	Day, Year)	
	10001		•	1			00	0573	33	10	0 119 10	9	
	Redy		P T WAR A M	ho completed cause of de	eath (Item 23a	(Type, F	Print)	Malan	50.1.	(100 -	MA	2180/1	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Fegistra	ar's Signature	n	in al	DILLER	JULIL	N. W.	7. 100	21009	
	Regist	ar	061 2 2	2009 Line	m B.	4	arks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2009 Isabel Manas Quiroga October 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 220-08-3941 Oct 9, 1920 Argentina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Evansian instituted at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Montgomery Brookeville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 18632 Queen Elizabeth Drive 20833 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Specify: White þ 3 Widowed 4 Divorced Spanish Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ၉ Carlos Manas Antona Bernardo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graciela Quiroga/daughter 18632 Queen Elizabeth Drive Brookeville, MD 20833 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 10/23/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Coinga Homes Chemation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the diffease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or all a consequence of) Failure /Medical 424h **Examiner** acrtic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed CHF and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred al or Attenative after death, eral Director: A' 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

Richard Kinnaird, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2009

egistrar's Signatur

29c. License number

D68658

3A21 Benson Ave. #100 Baltimore, MD 21227

29d. Date signed (Month, Day, Year)

22/04

			For State Registrar	State of Mary	•	rtment of F tificate of l			ıene _{eg. No.} 2 ∩ ∩ C	35650
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Lawrence Keit	h Roche,	Jr.			0ctober	19, 2009	6:54 P. [™]
	Examin	er	4a. Facility Name (If not institution, give st				Location of Death		4c. County of Dea	
*	Francis		Shady Grove Advent 5. Social Security Number 6. Sex		n yrs. last birthday)	Rockvi If Under 1 Year	.11e If Under 24 Hrs.	8. Date of Birth	Montgom 9. Bi	rthplace (State or Foreign
	Funeral Director				43 Yrs.	Months Days	Hours Min.	Month, Day, Dec. 3,	1965 Mar	ountry) yland
	pu "		Usual Residence of Decedent 10a, State 10b. County	11	Dc. City, Town or Loc	cation				10d. Inside City Limits
	faryla f shov	ō								1 XYes 2 No
	the M	Directo	Maryland Frederick 10e. Street and Number		New Mar	10f. Zip Code		1	0g. Citizen of What C	country?
	h with		5611 Old New Mark	et Road		217	74		U.S.A.	
	ems 2	Funeral		2. Was Decedent Eve Armed Forces?	er in U.S. 13. V		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventher must be multified at	by	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 XNo If Yes, Give Year or Dates:		I∐Yes 2∏XNo	Specify:		Specific	hite
2	72 hc	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	16a. Deced	dent's Usual Occup kind of work done o	ation during most of work i)	king	16b. Kind of Business	s/Industry
121	within ene. than '	d mo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retired [nstaller			Carpet	
Q 7	filed Hygik other ent,	Be Co	17. Father's Name (First, Middle, Last)			Installer		ne (First, Middle, I	Maiden Surname)	
lan	Aental Aental rked tic ev	TO B	Lawrence Keith	Roche, Sr	•		Patrio	cia Rae	Roberson	
ar)	2 short and fisma		19a. Informant's Name/Relationship (Type							Zip Code) 21774
<u>ຂ</u>	and lealth m 27 her tr		Mindy L. Roche - W				Market I		ew Market, 20c. Location - City o	
פֿר	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Re	movai from State	20b. Place of Dispos cemetery, crem		i		•	
₽	artmel artmel ortant Injury		4 ☐ Dollation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licenses		Metropoli	Ltan Crem . Name and Addre	100	10/21/09	Alexandr	ia, Virginia
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ex once.	5 11	Honest L.	Villiam	M 2	loleswort 26401 Rid	h-Willian ge Road.	Damascı	Funeral H us, Maryla	nd 20872
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		vascular	Accident				
	Examiner			Due to (or as a co						
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dub to (or as a co	crative Se	psis				
	cuted nd ransit	Examiner	that initiated events C.		's Granul	omatosis				
Ö,	ifficate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	icate l physicate is the b	edical	d.							
	± 5, 60 I		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of					23d. Date of d	elivery
. Box	death le atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown		Ctopic pregnanc Other (specify)	y		Month	Day Year
P.O.	at the de	Phys	9 Unknown					One Dida	haasa waa aantiibuta	to the equal of death?
rds,	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Completed by	Part II. Other significant conditions cont Hypertension	abuting to death but n	not resulting in the ur	nderlying cause giv	en in Part I.	1 □ Ye		to the cause of death? Probably 4 ☐ Unknown
000	law require as been si 2 should t	plet						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
		Com						perfor	med? death?	s 2 No
Z Z	ector,	Be	25. Was case referred to medical examiner?	ospital:		ot 3 🗆 DOA Oth	26. Place of Dea			
ō	Phys rrthis rral dii	1. To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	2 ER/Outpatien 28b. Time of	IL JUDON	4 L Nuising II		ence 6 Other (Sp ow injury occurred	pecify)
o	nding Ph	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yo	<i>(ear)</i> Injury		kí? Yes 2 □ No		, ,	
Division of Vital Records,	or Attendent fler deat in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre 'Specify)	eet, factory, office		28f. Location (S City or Town	treet and Number or I n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, to make the filled in by the funeral director, it is a second		29a. Certifier 1 Check only one) 1 Medical Examin	er: On the basis of ex	kamination and/or in					
	o the vithin 2 o the omple	Medical		and manner stated		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
	->-0		29b. Signature and title of certifier	JII WD	>	D 53	3317		October 20	0, 2009
	λ		30. Name and address of person who con			Print)		-		
	7	W	Joseph A. Ball M.I			k Road, #	# 213, G	aithersb	urg, Mary	land 20877
	Sta Registr		31. Date filed (Month, Day, Year) OCT 21	32. Registral's 2009	solgnature A.	parked	•			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) oct. 17, 2009 **Physician** 11:25a M Rodas Carlos Alberto /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville Shady Grove Adventist ROCKVIIII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min.) | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (Sountry) | 9. Birthplace (So 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 1 M 2 ☐ F **Funeral** Months 59 **Director** 219-27-6133 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County show or than "natural", or Items 23a or 28a-f show Germantown Md Montgomery 1 ☐Yes 2X No 10f. Zin Code 10g. Citizen of What Country? 10e, Street and Number 20874 USA 13436 Fountain Club Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1. Yes 2□No 3 Widowed 4 Divorced El Salvadoran Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Worker Cafeteria 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Ment item 27 is marked rother traumatic e Jose Elias Rivera Rodas Rosa Elia Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eduardo Elias Rodas/brother 9220 Canterbury Riding Laurel, Md 20723 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 10/22/2009 Silver Spring, Md 21. Signatur Funeral Service PHILIPADER TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute myocardial infarction Due to (or as a consequence of): disease or condition resulting in death) minutes /Medical Diabetes mellitus Examiner yrs. Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2KNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number October 17, 2009 30. Name and address of person who comp ed cause of death (Item 23a) Type, Print) William Dooley M.D. 9901 Medical Center Dr. Rockville, Md 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State

Registrar

OCT 23

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #5, 11, 10-28-09, per Filipper Beath

Reg. No. 2. Date of Death Physician/ Mary Rita Smith October | 3: Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Health and Rehab Ellicott City Howard 5. Social Security Number 216 07 3256 216-07-4256 7. Age (In yrs. last birthday) 90 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Days Hours Min. (Month, Day, Year) 8/22/1919 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 10f. Zip Code 1 Yes 2 X No MD Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 3000 N. Ridge Rd 21042 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Diversed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeping Hotel Catering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Bohn Mary Ellen Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Smith / Son 3210 Birchmede Dr., Ellicott City, MD 21042 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 5 ☐ Other (Specify) Crest Lawn Mem. Gdns. 10/27/2009 Marriottsville, MD 21. Signatur of Foneral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Altero scleno la Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year funeral director, page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate I ☐ Yes 2☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: Aft
bleted filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier October 22 2009 1) 30641 61ammy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1239 (Type, Print) Back Kiver Meck Read Balhown Marylod 2/22 Sa ba palh 201-69

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

		Please Type or Prin			ndelible Ink partment of F				le.
		1 - State Registrar		C	ertificate of	Death		Reg. No. 2	19 35653
Physi	oion	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day \	3. Time of Death
	dical	ROBERT E. SPADY SR	•				OCTOB FR	- 19, 21	009 07: 25 AM
Exam	iner	4a. Facility Name (If not institution, give street and number)				r Location of Death		4c. County of N/A	Death
Funera	al l		(In yrs.	last birthda	BALT]	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplace (State or Foreign
Directo		229-54-7072 ¹ X ^{M 2□ F} 6	7	Yrs.	Months Days	Hours Min.	(Month, Da		VIRGINIA
and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	v. Town or	Location				10d. Inside City Limits
Maryli f sho	ō		MADT	אר פידי	ATION				1 ☐ Yes 2X No
n the rr 28a	Direc	10e. Street and Number	PIXIL	ON DI	10f. Zip Code			10g. Citizen of Wh	at Country?
If it is within 72 hours after death with the Maryland Hygiene. Hygiene. With than "natural", or Items 23a or 28a-f show ent, the Modical Exercitive must be investigated.	ra D	28003 HOLLAND CROSSING ROA	D		21218	3		USA	
er dea	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?		S. 1	 Was Decedent of Horizontal If Yes, specify Cubin 	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black,	- American Indian, White, etc.
rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 X No	Specify:		Specify:	WHITE
2 hou		15. Decedent's Education			cedent's Usual Occup			16b. Kind of Busi	iness/Industry
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2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	T ₀	19a. Informant's Name/Relationship (Type. Print)		19b. Ma	ailing Address (Street				tate, Zip Code)
s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The file of t		FRANCES A. CAREY/DAUGHTER		3275	5 DOWNING	RD., DELM	MAR, MAI	RYLAND 21	.875
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. P	lace of Dis	sposition (Name of rematory or other place	ce)	Date		ity or Town, State
Pages tment of tant: If Its		4 □ Donation 5 □ Other (Specify)	PIT'	TSVIL	LE CEMETER	<u> </u>	23, 200	PITTSVI	LLE, MARYLAND
permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau	Suce	21. Signatury of Funeral Service Licensee			22. Name and Addre	•			
		23a. Part 1. Enter the disease, or complications that caused	the death		7.7				DELAWARE 1997. Approximate
Physicia		shock, or heart failure. List only one cause on each lin	e. 			-	, ,		Interval Between Onset and Death
/Medica	_	disease or condition resulting in death) a. Due to (or as a			PNEUM	GAIA			4 1/13
Examine		Surrentially list our lite on	BRO	VASC	MAR	ACUPE	NT		11 DAYS
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Solution of the Solution of th	-	d							
The law requires that the death certificate are has been signed by the attending physing 2 should be detached for use as the I	Physician/Medica								
ath ce ttendi	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome	2 🗌 Feta	l death	3 ☐ Ectopic pregnanc	су		23d. Date Mont	of delivery th Day Year
at the de by the a tached f	ysic	1 Yes 2 No 4 Pregnant at 9 Unknown	time of d	leath	5 ☐ Other (specify) _				
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quires an sign	ed by						1 🗆 '	Yes 2 □ No 3	□ Probably 4 🗗 Unknown
law requir as been s 2 should	Completed						24a. Was	an 24b. W	ere autopsy findings available ior to completion of cause of
n: The I lificate ha	Com						perfo	rmed/? de	eath? □Yes 2□No
Attending Physician: r death. ector: After this certifice by the funeral director, p	Be	25. Was case referred to medical examiner?			Ott	26. Place of Deat		-	
Physicla rr this cert aral director	년: 1:1	27. Manner of Death 28a. Date of Injul	v	ER/Outpat 28b. Time		T I Italianing inc		dence 6 Other	
nding Phy ath. r: After thi	atior	1 Natural 5 Pending (Month, Ďa) 2 Accident investigation	, Year)	Injur		rkí? ÍYes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	
er deg rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ry - At ho	ome, farm,	street, factory, office		28f. Location (or Rural Route Number,
ital o	Se	- 1							
To the Hospital or Attending Swithin 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of Check only one) 2 ☐ Medical Examiner: On the basis of and manner sta	examina						
o the	Mec	29b. Signature and title of certifier	ieu.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
M.		> nunch , Ma	>		AT 2	438946	2	OCTUBER	19,2009
12	1	30. Name and address of person who completed cause of de							
V		HEE JOO N. PARK, N	AD /	U NIC	in memor	ZIAL HOS	PITAL,	BALTIN	IORE, MD
S Regis	itate strar	31. Date filed (Month, Pay, Year) 32. Registra 22 2009	o oigna	b	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sakemiller 10 950 M Sharon Lee 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomica Salisbur oastal H OSPICE at the 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Days 1 □ M 2 🕱 F Months Hours Min. 221-28-1462 Director 64 02/21/1945 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ltem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the two local Examinations of the recognition at 1 Yes 2 No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 422 Pinehurst Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or ite Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔼 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Lawrence Nichols Covey Sylvie Burtelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry D. Sakemiller/husband 422 Pinehurst ave., Salisbury, MD 21801 Baltimore. Pages 1 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Imporant: If Ite
any in ury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/20/09 Salisbury, MD of Fureral Service Licensee 22H0110Wdy Tuneral Home Professional Association 6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MALIGNANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the 9 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2/ENO 2 218 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No HOSPICK Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Mariner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053410

State Registrar Coffunam

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130 K

32. Registrar's Signature

WARRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 1637 October 23, Ella Katherine Spring /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Caroline Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months Min. 1 ☐ M 2 🕱 F May 12, 1911 New York Director 063-10-5401 98 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at gence. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County M⊈ Yes 2 □ No Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States ofAmeric by Funeral 21629 <u> ?13 Maryland Avenue</u> Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **2**☐ No If Yes, Give 11. Marita Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 □ Widowed 4 □ Divorced Year or Dates: Caucasian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HS Grad Addressograph Operator Savings Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mary Frances Zanini Martin Frederick Wacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) |1441 Wellington Court, Cape Coral Florida 33904 Daughter Marion Beckwith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Gate of Heaven Cemetery Silver Spring, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility Moore Fureral Home, P. A. 12 South Second Street, Denton, Maryland 21629 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cers COMOVAN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Ponknown Completed was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital or Attending Physician: neral Director: A filled in by the fu within 24 hours after d

To the Funeral Direct

completely filled in by

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature OCT 27 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State

Medical

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1- State Registrar AMEND#26perMD, 10-23-09, BMW, Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:04 am Harold Spector October 20. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 X M 2 □ F Months Days Hours Min 179-14-6958 Director 86 11/07/1922 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinations to recitied at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 u.s.A. Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Š Specify: 3 Nidowed 4 Divorced WWII Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Furniture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boris Spector Min Fligelman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau Robert L. Spector - Son 8410 St. Regis Way, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kesher Zion Cemetery | 10/23/2009 Shillington, PA 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** ACTERIA KNOWN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide turcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 018084 9+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (N

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State of Maryland / Department of Health and Mental Hygiene 35657 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 21, 2009 **Physician** Max Joseph Schmitt 11:16 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 19045 Canadian Court Montgomery Village Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 😡 M 2 🗆 F 90 Director 216-38-3104 08/25/1919 Germany Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examination is quifted at Director 1x Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 19045 Canadian Court 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Max Schmitt Else Glaessing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 19045 Canadian Court Montgomery Village, MD. 20886 Bernard Schmitt (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State October 26 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 2009 Germantown, Maryland 21. Signature of Funeral Fe vice Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock during a failure. List only one cause on each line. Immedia Cause (Final disease or condition resulting in death) 0278272889-**Physician** Metastatic Sarcoma /Medical 10/21/2009 Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate and the cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death The law requires that the death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending (Month, Day Year) 1 XNatural 5 Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0047227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3289 Woodburn Rd #390 Annandale VA 22003 Felasta M Woodyo MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Inko Ensure All Copies Are Legible.
Amend Item 20b per FH G89 Plack Indelible Inko Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 35658 Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Month 10 7:00 PM Day G SNegd **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner M ARD ()enton 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace Country) (State or Foreign **Funeral** Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Department of Health and Mental Hygiene. Introducing them 23a or 28a-f st important: If item 27 is marked other than "natural", or items 23a or 28a-f st important: If item 27 is marked other than your jujury or other traumatic event, the Medical Examiner must be notified once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21629 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) 5+1 College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madison Nead HNNIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Snead dith Rd Denton MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition TAY lor's Burial 2 Cremation 3 F 3 Removal from State Ceme 10/24/2009 21. Sig Ture of Funeral Service Licensee 22 Name and Address of Facility
FOX FUNDVAI HOME fex funeral rules n. Fox Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ROBABI Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical as the t attending IF FEMALE: detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the 9 Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes director, page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an has autopsy perform 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate h 2 No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2N No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide tel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confi Name and address completed cause of death (Item 23a) (Type, Print) DOMINGDAL EDERALBURI 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar Barks

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	Physici /Medio		Rose	Mary		Shaffer				Oct 2			0425	М
	Examir	ner	4a. Facility Name (If not institution Allegany Cour	nty Nursing Ho	ome			berlan	d		4c. County Allec	gany		
	Funeral Director		5. Social Security Number 214-05-8381	6. Sex 7. A(ge (In yrs. 96	last birthday) Yrs.	If Under 1 Your Months Da		ler 24 Hrs. s Min.	8. Date of Birt (Month, Da) Oct 2	4, 1913	9. Birthp. Coun	MD	or Foreign
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Baltimore, Mary	12 shoth and 7 is m		19a. Informant's Name/Relation Michele Pude		ghter	19b. Mailir 572	ng Address (Sti Patterso	eet and Nun n Aveni	nber or Rura U e	a <i>l R</i> ou <i>te Numbe</i> Cum	r, City or Town, berland	State, Zip	Code)	502
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			30. Name and address of person who co	mpleted cause of					0			Pri-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 0415AM Watkinson Julia Ann 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3A41560 Wicam 100 *PENINSULD* KegIONAL DICAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Virginia Days Min 1□M 2**X**F 10/25/1929 Director 79 227-34-3207 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 No Director Parksley VA Accomack 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a U.S.A. Funeral 28424 23421 Whitesneck Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify ^{Specify:}White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. In portant: If item 27 is marked other the any Injury or other traumatic event, that Medical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hickman Thomas East Annie Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter DeCormis Watkinson(Spouse) 28424 Whitesneck Rd., Parksley, VA 23421 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Cemetery 10/15/2009 Onancock, Virginia 21. Signature of Funeral Service Licensee Williams Funeral Home Williams. Parksley Road, Parksley, Virginia 23421 23a. Part 1 Enter the disease, or complications that stused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 3 /Medical Due to (or as a consequence of): Examiner Dely d Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ner Due to (or as a consequence of): The law requires that the death certificate be executed Exami Hil W attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a I be detached for 1 ☐ Yes 2 ☑ No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No of Vital r this certific ral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

100 C. 32. Registrar's Signature

(8)

address of person who completed cause of death (Item 23a) (Type, Print)

H0056197

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 35662 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Mary Colleen Warner October 18 2009 3:40a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14605 Frederick Road Cooksville Howard 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖸 F Months Hours Min. Director 53 213-66-7527 Aug. 21, 1956 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the located Examinat rust be nottined at Director 1 ☐ Yes 2√7 No Maryland Howard <u>Cooksville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14605 Frederick Road Funeral 21723 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 9 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teachers Assistant Howard County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Noon 2 Dorothy Hemelt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if item 27 is any Injury or other trau <u>Karl A. Warner/ Spouse</u> 14605 Frederick Road, Cooksville, Maryland 21723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.24,2009 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland. 21. Signature Juneral Service License 22. Name and Address of Facility
Stauffer Funeral Homes 1621 Opposumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician oreast Canter disease or conditior resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a d be detached for □Yes 2.2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To the Funeral C

completely filled filled Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 D40854 10/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rultimore 21505 Parl Place Darid Risebers and 31. Date filed (Month, Day, 32. Registrar's Signature State arke BARRAM Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		epartment of F Sertificate of S			giene Reg. No.?	2009	35663
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	_		3. Time of Death
max	/Medio		RANDOLPH JOS 4a. Facility Name (If not institution, give s		IR .	4h City Town o	r Location of Deat			, 2009	1:25 A M
أمحدر	Examin	er	43 Orchard Drive				ersburg	''		ONTGOMER	Y
	Funeral Director		029-10-3033	7. Age (I	ln yrs. last birthd 88 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Mar. 2	h y, Year) 4,19	9. Birthpl Count Mas	ace (State or Foreign ry) S
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town o	r Location	_			10	d. Inside City Limits
	e Mary a-f sh tified	Director	NY Nassau		Wes	t Hempstea	d				1 ☐ Yes 2 📆 No
	ath with th 23a or 28 ust be no		10e. Street and Number 753 Janos Lane			10f. Zip Code 11	552		-	zen of What Count	ry?
3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3☐ Widowed 4 ☐ Divorced	2. Was Decedent Eve Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		4. Race - America Black, White, e Specify: Blac	tc.
21215-0036	within 72 h jene. • than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(G	ecedent's Usual Occup live kind of work done fe. DO NOT use retired Gineer	ation during most of wor d)	rking		nd of Business/Ind oklyn N 러	*
b	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,			· · · · · · · · · · · · · · · · · · ·
<u> Yaa</u>	ould b I Ment Iarked	고 B	Randolph Walker					ed Brewe			
Maryland	d 2 sh Ith and Ith sm 17 is m traum	1.	19a. Informant's Name/Relationship (Typ. Lauren Newman (Da		ı	ailing Address <i>(Street</i> Orchard Dr					Code)
re,	item 2		20a. Method of Disposition			sposition (Name of crematory or other place		Date		cation - City or Tov	vn, State
altimore,	Page ment c ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amovai from State	_ (\	Crematory	10/2	0/09	Han	over, MD	
Balt	permit Depart Import any Inj		21. Signa ure of Funeral Service Lice Servic	Lucus	h	22. Name and Addre				•	
L			23a. Part 1. Enter the disease, or comple shock, or heart failure. List only on Immediate Cause (Final	ations that caused the cause on each line.	e death. Do not	enter the mode of dyir	ng, such as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
- L	Physician /Medical		disease or condition resulting in death)	Due to (or as a co					-		
	Examiner		Sequentially list conditions	Schsis							_
5	rted s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	, ,						
68760,	tificate be executed ig physician and as the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a co	es Mell onsequence of):	ıtus		b			
687	tificate ig phys as the	ledical	d.								
O. Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as I	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У		2	3d. Date of deliver Month	ry Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but n	ot resulting in th	e underlying cause giv	en in Part I.		bacco us	se contribute to the	e cause of death?
al Records,		Completed						24a. Was a autop perfor 1 □ Yes	sy med?	24b. Were autop prior to con death? 1 ☐ Yes	sy findings available apletion of cause of
Vita	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	ospital:		tiont 2 DOA Oth		ath (Check only or			Daughter's
o t	g Phys ter this teral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Ye	28b. Tim	e of 28c. Injur	4 LI Nursing F	lome 5 ☐ Resid 28d. Describe h		Cocurred	Home
Sior	or Attending Physician: after death. Director: After this certific in by the funeral director,	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(WOTH), Day, 16	e <i>ar)</i> Inju		Yes 2 □ No				
Division of	pital or Attours after deral Direct filled in by	Certification: T	4 Homicide determined	28e. Place of Injury building, etc. (3	Specify)			City or Tow	n, State)	Number or Rural	
	within 24 hours af	edical	29a. Certifier 1 ★ Certifying Phys (Check only one)	ician: To the best of mer: On the basis of ex and manner stated	amination and/o	eath occurred at the til or investigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To the within compl	Me	29b. Signature and title of certifier	\		29c. Licens	e number		29d. Date	e signed (Month, E	Pay, Year)
	1>		Victor E.	derry, 1		D209	86		10	/20/09	
			30. Name and address of person who cor Victor E. Herr		n (Item 23a) (Typ 9001 Woo	oe, Print) Odyard Road	l, Clinto	n, MD 20	735		
i	Sta Registr		31. Date filed (Month, Day, Year)	37 Registrar's	Signature	200					

DHMH 17 Rev 1/2001

State Registrar

OCT 2 3 2009 DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIANCARPENTER

31. Date filed (Month, Day, Year)

9901 MEDICAL CENTER DR. ROCKVILLE MD. 20850

State of Maryland / Department of Health and Mental Hygiene 35665 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Connie M. Arcamone Nov. 6 2009 12:35a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Heights Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 12-12-1920 9. Birthplace (State or Foreign Country)
Phila. PA. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** F 88 160-18-6746 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Anne Arundel 1 ☐Yes 2 No Director Gambrills the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with "natural", or items 23a or 730 Rte. 21054 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examination. Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ģ 1 ∐Yes 2**X** No Specify White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Corp. 12th Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Cimieri Vincenza Botto ပ 19a. Informant's Name/Relationship (Type. Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 Saxon Court, The Villages, Fl. 32162 Paul Battaglini 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-11-09 Yeadon, PA Holy Cross Cem. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Joseph N. Zannino Jr 263 S. Conkling St.Baltimore, MD 21. Signature of Funeral Service Licensee Jr. FH ID 21224 Lu 23a. Part 1. Enter the disease shock, or heart tailure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line Immediate Cause (Fnal **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-ti Due to (or as a consequence of): O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 MNo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown Division of Vital Records, P. signed I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an performed? Yes 2 2No certificate ! 1 TYes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) TAJE TOGDIL Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No HOW Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital CertifyIng Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co ed cause of death (Item 25a) (Type 40 31. Date filed (Month, Day, 32. Registrar's Signature Registrar NOV 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 35666 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 12:42 PM NOVEMBER THOMAS ANOWECK 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE
If Under 1 Year | If Under 24 Hrs. HOPKINS RAYVIEW MEDICAL CENTER Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 □ F Days Hours Min. 213-18-4901 Director 87 Aug. 15.1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Market Francisco. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Dunda1k 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21222 United States 2403 West Branch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** No Specify. ģ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Warehouseman Steel Industry 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Anoweck Mary Trybus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Rendell(Daughter) 421 Oakwood Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Oak Lawn Cemetery 4 ☐ Dopation _ 5 ☐ Other (Specify) 11/9/2009 Baltimore, Maryland uneral Service License Signature 22. Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Duda-Ruck Funeral Home of Dundalk, 21222 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PULSELESS ELECTRICAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** END STAGE RENAL DISEASE WEEKS Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and use as the burial-tran resulting in death) Last Due to (or as a consequence of): physician attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 ☐ Other (specify) JYes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has birector, page 2 sl 24a. Was an autopsy 1 ☐ Yes 2 1No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

1×01

Box 68760,

P.0.

Records,

Division of Vital

State Registrar 29b. Signature and title of certifier

SHIN-BEY

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

CHANG

and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

5,2005

NOVEMBER

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#8perFH, 6896, 11/6/09, WS
State of Maryland / Department of Health and Mental Hygiene 0 0 9 35667 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year October 2009 1815 /Medical Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death County of Death Ray thwes Daltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Manth, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fraction Exeminar must be notified at 10d. Inside City Limits Director 1 Yes 2 No Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3400 USA 0/20 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Be Completed by Specify: Specify: 1ac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other traumatic event, 1000. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mare 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) lawn Cemetry 22. Name and Address of Facility of Funeral Service Ligenses 400 la 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart fallure. List only one cause on each line Immediate Cause (Final **Physician** . STAGE Cardiom disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a currequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy this certificate performed 2 WNo 1 ☐ Yes neral **Director:** After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 🗌 Yes 2 **(**No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 [L'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only

State Registrar 29b. Signature and title of certifier

N.S. Rajapakse, MID

SKAJAPanseniP.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

32. Registrar's Signature

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

main St., Suite

29c. License number

D0057465

Reisterstown,

29d. Date signed (Month, Day, Year)

10/31/09

MD. 21136

Physician

1 - For State Registrar

/Medical Chevelle Brown									Novembe	r 1, 2009	7:00 AM
	Exami	ner	4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Dea	ath
			Anne	Arundel	Medical Ce	enter	Annapo	lis		Anne Ar	undel
	Funeral		5. Social Security N			e (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country)
	Director		578-	94-5491	□M 2ÅF	44	rs. Moriais Days	Tiodio Isini.	Jan 8,	1965 Wa	shington,DC
	O		Usual Residence of	f Decedent							
	ylan		10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mar Fed	호	MD	Anne Ar	unde1	Anı	napolis				1 □Yes 2√ No
	the 288	re	10e, Street and Nu	mber			10f. Zip Code		1	0g. Citizen of What C	Country?
	with a or	ā	900 Van	Buren St	reet			21403		USA	
	s 23	Funeral Director	<u></u>	1-	140 144- 15	5 i- II 0	40.11/- 0				
	er de	5	11. Marital Status	unk	12. Was Decedent Armed Forces?		13. Was Decedent of I If Yes, specify Cub	nispanic Origin? (S) an, Mexican, Puert	pecify Yes of No- o Rican, etc.)	14. Race - Am Black, Whi	
36	o, or	by F		ried 2 Married	1 □Yes 2 □ If Yes, Give	No unk	1 □Yes 21√∑No	Specify:		Specify: b	1 ank
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Examinat be notified at	D D	3 Widowed		Year or Dates:		*		him by		- waste
'n	72 h	Completed	(Spe	 Decedent's Educify only highest gra 	ducation ade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation durina most of wori	kina	16b. Kind of Business	s/Industry
7	filed within Hygiene. Ither than "	du	Elementary/Seco	ondary (0-12)	College (1-4or 5	5+)	life. DO NOT use retire	rd)			
7	yd w /gier	ပ္ပြဲ	unk 10		ınk 0		Disabled			Disable	d
b	oth yearl	Be	17. Father's Name	(First, Middle, Last,)		unk	18. Mother's Nam	ne (First, Middle, N	Maiden Surname)	-unk-
<u>a</u>	lid by Ments rked ric e	To						Sh	elia Br	own	
<u> </u>	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc. Me	-	19a. Informant's N	ame/Relationship (Type, Print)	19b.	Mailing Address (Street	l Land Number er Ru	ral Route Number	City or Jown, State	Zin Code)
Maryland 2121	d2: Itha Itha 27 Is trat		Anne Ari	Brown/sis	Type Print ter-In-lav	ar S	Mailing Address (Street 1001 Medica	ater Plac	e Mitche	LIVILLE, M	$\frac{0.720721}{0.1}$
ė	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational Leuroffled at		20a. Method of Dis		2002 0000					20c. Location - City o	
õ	tiges if it		1 □ Burial 2	XCremation 3 □	Removal from State	1	Disposition (Name of crematory or other pla			•	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.				y) in state	- Chambe	rs Cremator			Riverdale	
3al	permi Depar Impor any ir		21. Signature of	ineral Sarvice Licer	Wate, hir	ector	22. N. me and Addr	ss of Fac. MC.	augniin	Runeral H	me 20020
	<u>σ</u> □ ≒ α ο ι		1480	22/1/	well-		Dalcimorc	-110 - 2120	71		on, D.C. 20020
			23a. Part 1. Enter t	the disease, or com	plications that caused one cause on each li	the death. Do n	ot enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause		0110 04400 011 04011 11		1 - 600	44	0		Onset and Death
	/Medical		resulting in death)	on .	a. Due to (or as	nger	we rea	N/a	ure		-
	Examiner			•	Due to (or as	conse derice o	1.	•			
		<u></u>	Sequentially list co	nditions,	b. Due to for as	a onsequence o	Jenno	1			
	ted Isit	Examiner	cause. Enter Unde Cause (Disease or	erlying	Due to tot as	Vacquerice	·)·				
	and -trar	xau	that initiated events resulting in death)	S Table	C. Due to (or as	a consequence o	n.				
90,	be ex		,		Due to (or as	a consequence o).				
68760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	hysician/Medical			d		1				
9	ing p	Mec	IF FEMALE:					4			
Вох	eath cer attendin for use	an/	23b. Was deceden	t pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 ☐ Ectopic pregnance	CV.		23d. Date of de	
	ne death the atte	sici	in the past 12 1 ☐ Yes 2	No	4 ☐ Pregnant a 9 ☐ Unknown		5 ☐ Other (specify) _	-,		Month	Day Year
0.0	t the de by the ached		9 🗆 Unknown		9 🗆 UNKNOWN						
_	law requires that as been signed b 2 should be deta	by P	Part II. Other signi	ficant conditions of	ontributing to death b	ut not resulting in	the underlying cause giv	∕ e n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Ď	uire: n sig Id be		chroni	ic obest	ructive	Dulm	mary de	me	1 □ Ye	s 2 No 3 F	Probably 4 Unknown
<u>S</u>	v req bee	ete			No.	U	0		24: 11/	0.00	
ě	Φ — Φ	μ							24a. Was ar autops	y prior to	autopsy findings available completion of cause of
=	: The cate had page	Completed							perform 1 □ Yes 2	ned? death?	s 2 No
Division of Vital Records,	Physician; The this certificate ral director, pag	Be	25. Was case refer examiner?	red to medical					th (Check only one	e)	
=	ys gir	ဥ	1 ☐ Yes 2 ☐	110	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient 3 DOA Oth	ier: 4 □ Nursing He	ome 5 Reside	nce 6 Other (Sp	ecify)
0	ng P fter t nera		27. Manner of Deat	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Ti v. <i>Year</i>) In	me of 28c. Injury	ry at	28d. Describe ho	w injury occurred	
<u>ō</u>	Attending r death. ector: After by the fune	aţic	2 Accident	investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 □ No			
<u>S</u>	Atte	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju	ry - At home, fari	n, street, factory, office	19 = 1		reet and Number or F	Rural Route Number,
Ö	al or afte Dir din	Certification:	4 🗀 Homicide		building, etc	c. (Specify)			City or Town	, State)	
	Hospital 24 hours 8 Funeral stely filled		29a. Certifier	LecrtifyIng Ph	ysician: To the best	of my knowledge,	death occurred at the ti	me, date and place	, and due to the ca	ause(s) and manner a	as stated.
	e Ho 24 F e Fu	Medical	(Check only one)	2☐ Medical Exam	niner: On the basis o and manner sta	f examination and	or investigation, in my	opinion, death occu	rred at the time, da	ate and place, and du	ie to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signa are and	title pcertif			29c. Licens	se number	25	9d. Date signed (Mor	oth, Day, Year)
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•		-		1			-	, ,		"1-10	/
			30. Name and add	of person who	completed cause of d	eath (Item 23a) (1	ype, Print)	1	Λ	. /	-17 - 11-
			31. Date filed Won	401,107	W MU	ar's Signature	reduced 1	Lmd.	744MD	porus,	UND SIME
	Sta Registr		NO	V () 6 2009	DZ. Hegistra	ar a digricature	ares	0 .			
			3 ***		The Court of the Court	ALL A THEOLOGY					

			for State Registrar	State of	of Marylar		artment of <i>tificate of</i>	Health and Death	Mental Hy	giene Reg. No. 2	009	35669
Ī	Physici /Medic		Decedent's Name (First, Middle		vian M.	Bailey			2. Date of De Month	ath Day	Year	3. Time of Death
)	Examin		4a. Facility Name (If not institution Sanctuary of I	_	,		4b. City, Town, Burtons	or Location of Deat			unty of Death	1
	Funeral Director	-	5. Social Security Number 213-05-0221	6. Sex 1 M 2 M F	7. Age (In yrs. 98	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs		h y, Year)	Coui	place (State or Foreign ntry)
	Maryland I-f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County MD Monto	jomery		ty, Town or Lo		_			1	0d. Inside City Limits 1 X Yes 2 No
	with the a or 28æ be noti	Director	10e. Street and Number				10f. Zip Code				of What Cour	ntry?
0000	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3415 Greencast 11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed F ried 1 Yes	2 XNo live		20866 Was Decedent of f Yes, specify Cu 1 □ Yes 2 🗓 No	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	14.	B.A. Race - Americ Black, White, ecify: Wh:	etc.
0-0171	within 72 ho ene. than "natur h Mccical i	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 1 2	nt's Education est grade completed)) (1-4or 5+)	Give life. L	dent's Usual Occu kind of work done OO NOT use retin	ipation e during most of wo ed)	orking		of Business/In	dustry
ומונם ע	uld be filed Mental Hygi Irked other Itic event, ti	To Be Co	17. Father's Name (First, Middle, Howard Hopkins			TOME	maker		me (First, Middle, immee Hov	Maiden Sur		-
e, Mary	1 and 2 sho Health and I em 27 is ma ther trauma		19a. Informant's Name/Relations LeRoy Ruby / 20a. Method of Disposition	ship (Type. Print) Personal		1252		Road, C		ings,		nd 21722
all III C	Pages ment of I ant; if it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	cemetery, crer	natory or other pl	. G. Nov			,	aryland
Da	permit Depart import any Inj once.		21. Sign fure of Funeral Service	Li ense	M00	D		ress of Facility Funeral tt Ave.]			nd 207	07-4389
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause [Final disease or condition	r complications that only one cause on	caused the dear	th. Do not ent				_		Approximate Interval Between Onset and Death
MF.	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						
	cate be executed shysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	C	(or as a consec							
20/00,	ficate be e physiciar s the buri	dical		d								
.O. DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	utcome pf pregn birth 2 Feta gnant at time of a nown	al death 3□]Ectopic pregnan] Other (specify)	су		23d.	Date of deliv	ery Day Year
COINS, L	quires that en signed by	Ď	Part II. Other significant conditi	ons contributing to c	death but not res	sulting in the ur	nderlying cause g	iven in Part I.	23e. Did to			he cause of death?
חשבו וי	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death, within 24 hours after death, completely filled in by the funeral director, page 2 should be detached	Completed							24a. Was autop perfo 1∐ Yes		4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of
Vila	ysician is certifii director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hoepital:	Inpatient 2	ER/Outpatien	t 3 DOA O	hor	ath <i>(Check only d</i>		Other (Speci	fv)
	anding Phi ath, ir; After thi ne funeral o	ation: T	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date ng (Moi gation		28b. Time of Injury	28c. Inj		28d. Describe I			<i>,,</i>
	STo the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicíde 6 Could 4 Homicide determ	nined 28e. Place build			eet, factory, office		City or Tou	vn, State)		al Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certifyli (Check only one) 2 Medical	ng Physician: To th Examiner: On the l and mar	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)
R	withir Comp	Me	29b. Signature and title of certific	ees				nse number 005456		29d. Date si	igned (Month,	Day, Year)
v			30. Name and address of person Sunitha B		use of death (Iter	m 23a) (Type,	Drint)			Lucas	247.22	m02 c2.c
	Sta Registr		31. Date filed (Month, Day, Year)	0 6 2009	Regis far's Sign	ature .	parks	orna H	1-17	10015	parte	m020912

State of Maryland / Department of Health and Mental Hygiens 009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2009 **Physician** Nov. 8:10 a John Josh Bosley /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Westminster Carroll 5017 Grand Valley Rd. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 212-52-7716 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. In Department of Health and Mental Hyglene in Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, he "sedies Extern near the Pullish at 1 ☐Yes 2 No Westminster Maryland Carroll Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 U.S.A. 5017 Grand Valley Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1-∑Yes 2 □ No If Yes, Giv 9 0 8 -- 19'7 Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 White Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvin Bosley, Sr. Genevieve M. Morelock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 Fairground Ave. Taneytown, MD. 21787 Richard C. Smith, Jr .- stepson 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Nov Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Catonsville, Md. 6,2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, MD. 21102 21. Signature of Funeral Service Licensee Kents felloto Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final consequence of): **Physician** 10 months disease or condition resulting in death) /Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier upleted cause of death (Item 23a) (Type, Print) 30. Name and add 10 North Greene St. Baltimore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of N	Marylan		artment of F rtificate of I		Mental Hy	gien Reg. No	°2009	35671
		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month		ay Year	3. Time of Death
Physicia /Medic		Janine Y. Beac	:h						er 1	, 2009	13:25 [™]
Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, Town, or	r Location of Death			c. County of Deatl	
d		Montgomery Gene				01ney				lontgomer	
Funeral Director		5. Social Security Number 215-38-6385	6. Sex 1 ☐ M 2 🖾 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 12	th ay, Year , 192	9. Birti Co 25 Eng	hplace (State or Foreign untry) Land
pu. v		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
aryla shov	'n	,				cation					1 □Yes 2 No
the M	ect	Maryland Montgo	omery	Koc	kville	10f. Zip Code			10n. C	Citizen of What Co	untry?
with a or	۵		Dood			20853				ited Stat	
eath	era	14905 Westbury 11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of H	Ilspanic Origin? (Si	pecify Yes or No		14. Race - Ame	
perillinoie, Mai yiailio ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be ruillied at once.	by Funeral Director	1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Force	s? ∑ No		lfYes, specify Cuba 1 ∐Yes 2 MINo	an, Mexican, Puerto Specify:	Ricán, etc.)		Black, White	
2 hou	Completed	15. Decedent	's Education		16a. Dece	dent's Usual Occup	pation	l-in-		Kind of Business/	
hin 7.	ple	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of work done DO NOT use retired	during most of world)	King	1		lontgomery
d with	ρ		5+		Teach	er Specia	list		Cot	ınty	
d file	Be (17. Father's Name (First, Middle, I	Last)				18. Mother's Nam	ne (First, Middle	, Maide	en Surname)	
Ment Ment arked atic e	힏	Herbert Percy H	larrison				Hilda Ha	rrison			
2 sho and is ma		19a. Informant's Name/Relationsh	nip (Type. Print)		1	ng Address (Street					
and and n 27 n 27 ner tr		Peter E.M. Beac	h/Husband			Westbur					
Dalumore permit. Pages 1 Department of H mportant: If iter any Injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ite	clawn Me	sition (Name of matory or other plac m orial Park	2009	·	Roc		Maryland
permit. Departition of the permit of the per		21. Signature of Funeral Service I	Blut	M01.	Ro 548 30	bert A. Pum O West Mont	ess of Facility phrey Funer gomery Aven	al Home/R ue, Rockv	ockv ille	ille, Inc. , Maryland	20850
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. Ust Immediate Cause (Final	only one cause on each	h line.		ter the mode of dyi			arrest,	8	Approximate Interval Between Onset and Death 3 days
/Medical Examiner		disease or condition resulting in death)	a	as a conseq		ruccion w	TEH TEH	oracion			3 days
ted .	Examiner	Sequentially list conditions, it any, eaching to insure clate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for	as a conseq	uence of):						
ficate be executed physician and sthe burial-transit	al Exar	that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):		_				
physi physi the t	dical		d								
OI VICAL DECOLUS, F.O. DOX O Physician: The law requires that the death certific this certificate has been signed by the attending is ral director, page 2 should be detached for use as	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 Deta	Il death 3	☐ Ectopic pregnand ☐ Other (specify) _	cy			23d. Date of del Month	livery Day Year
ires that t signed by be detac	by Phy	Part II. Other significant condition	-			1.7					o the cause of death?
requ been shoulk	etec										
JI OI VILAI NECOLUS, Jing Physician: The law requires t Affer this certificate has been signs funeral director, page 2 should be c	Completed	Disease, Diabe		Tilles	LIHAI	breeding		1 □Yes	opsy ormed? 2 🖾 N	prior to death?	utopsy findings available completion of cause of
VICAL Ilcian: T certifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			_ Ott	26. Place of Dea				
Phys	은	1 Yes 2 No 27. Manner of Death	1 🔀 Inp		ER/Outpatie	nt 3 🗆 DOA	4 🗀 Nursing P	lome 5 ☐ Res 28d. Describe		6 ☐ Other (Spe	ecify)
Aling F	ioi	1 X Natural 5 ☐ Pendin	g (Month,	Day, Year)	Injury	Wor	k? Nes 2□No	Zou. Describe	now in	jury occurred	
ttend death stor: / the	icat	2 Accident investig	not be 280 Place of	Injury - At h	ome farm st	reet, factory, office	11es 2 110	28f Location	(Street	and Number or Ri	ural Route Number,
Invision or Attending after death. Director: After din by the fune	Certification:	4 ☐ Homicide determ	building	, etc. (Speci	fy)	cot, lactory, office		City or To	wn, Sta	ate)	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C		ng Physician: To the be Examiner: On the bas and manner	is of examina							
o the vithin o the	Me	29b. Signature applittle of certifier				29c. Licens	se number		29d. [Date signed (Mont	th, Day, Year)
L > F 0		> Ch An	~ ~			D1872	26		No	vember 2	2009
Δ		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type.				407	ACHIDET 7	,
σ		Arthur Schoeng				e Philip	Drive, 0	lney, M	ary.	land 208	32
Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa							
Registr	ar	30V 0 6 2	nng /	4. 1	1 Sec.	plani					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35672 State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 10 30 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Min. Months Days Hours 1 □ M 2 💢 F 187-18-5437 87 Jan 5, 1922 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Caroline Ridgely 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24870 Holsinger Lane 21660 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes_ 2 __XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) insurance agent farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles John Sterbach Alice Emma Legrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises.

Examiner

sician and burial-trans attending physician for use as the buria his certificate has been signed by the I director, page 2 should be detached a funeral ours after death.

neral Director: Al
filled in by the fur completely

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Kirk Beattle Jr/sor	ı	248/4 Ho	olsinger L	ane Ri	dgely, M	D 21660)				
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rel 4 ☒ Donation 5 ☐ Other (Specify)		Place of Disposition (Nemetery, crematory of	lame of r other place)	Date	20c.	Location - City or	Town, State				
	21. Signature of Funeral Service Licensee Romald S. We	ade Director		and Address of Facili Anatomy B	Bóard 6	555 W. Ba	ltimore	Street				
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	h. Do not enter the m $\mathcal{E} \mathcal{M} / \mathcal{S} \mathcal{P} \mathcal{H}$		s cardiac or re			Approximate Interval Between Onset and Death				
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseq	uence of):									
ysicianyme												
בת ושא הו	Part II. Other significant conditions contr	ributing to death but not res	ulting in the underlying	g cause given in Part	I.	23e. Did tobacco		o the cause of death? Probably 4 Unknown				
nubien						24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of				
n l	25. Was case referred to medical examiner?			26. Place	e of Death (C	Check only one)						
5	1☐Yes 2☐No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 🗆 N	lursing Home	5 ☐ Residence	6 ☐Other (Sp.	ecify)				
rincanon:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work?	28d	I. Describe how inj	ury occurred					
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f.	Location (Street City or Town, Sta	and Number or F ite)	tural Route Number,				
ealcal		cian: To the best of my kno er: On the basis of examina and manner stated.										
2	29b. Signature and title of certifler		2	29c. License number		29d. [Date signed (Mon	th, Day, Year)				
	D. U.			128580	2009	11	7-31-	2009				

State Registrar S GREENE ST BALTIMORE M) Z1201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Registrar's Signature

CHI

ALBERT

NOV 0 6 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 35673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death NOVEMBER **Physician** 2009 MILDRED **BROWN** 2:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7121 PARK HEIGHTS AVE. BALTIMORE N/A 8. Date of Birth (Month, Day, Year 12/21/1917 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 91 vrs If Under 1 Year | If Under 24 Hrs **Funeral** Months Days Hours Min. 1 □ M 2 X F 182-07-7538 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evan, in a count by coulding a MD 1 X Yes 2 □ No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 7121 PARK HEIGHTS AVE. #803 21215 USA Funeral death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other the any Injury or other trainment. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 □Yes 2 No Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No WHITE Specify: If Yes, Give Year or Dates: Specify: 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAX KARSH REBA UNKNOWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALISON RICHMAN / DAUGHTER 313 GARRISON FOREST RD., OWINGS MILLS, MD 21117 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State DRUID RIDGE 11/04/2009 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Si nature of Funeral Service Lilens e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Electrolyte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Dehydration use as the burial-tran and Due to (or as a consequence of) attending physician for use as the buriel P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ cate has been signated by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 5/10 cemebro 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 11/3/09 019914 completed cause of death (Item 23a) (Type, Print) 30. Name and address of 10753 Falls utterville TIFINE MO Day, 32. Registrar's Signature 31. Date filed State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35674 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. Day Vivian Elizabeth Cassel 2009 9:45P 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchirst Hospice Towson Social Security Number 214-10-4858 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 07/1/1/84/10921 9. Birthplace (State or Foreign Countril A 7. Age (In yrs. last birthday) 1 M 2 X F Days Min. Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Lutherville Timonium 1 Yes 2 No 10f. Zip Code 21093 10e. Street and Number 10g. Citizen of What Country? 252 Chantrey Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates 1 Tes 2 No Specify: 3 ₩idowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) MD Hospital Asso Elementary/Seconday (0-12) College (1-4 or 5+) Assist. President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Keller Betty Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 252 Chantrey Rd. Timon. Md 21093 Sat Kirin Khalsa/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Nov. Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Service Licenses 22. Name and Address of Facili@AFA/Stephen D.Lohrmann P.A. Green Pastures Dr. Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final FIBRILLATION Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Day Month Year 4 Pregnant 9 Unknown Pregnant at time of death

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

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Examiner

Funeral

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ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

I Hygiene.

permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

physician a attending p signed by the a should peen s s certificate has b lirector, page 2 s this To the Hospital or Attending Plywithin 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral I Director: After the funeral

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ũ resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Cher (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

NOVEMBER 6, 2004

State Registrar

DHMH 17 Rev 7/2009

6701 NOUMPLES ST. SUITE 415

Barker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUBBONAS, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alfred Cavallaro I. 10:35 A^M November 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Hours December 14,1926 Director 82 219-10-7330 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4039 St. Augustine Lane 21222 LISA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White "natural", 3 Divorced 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hourment of Health and Mental Hygiene. ant; If item 27 is marked other than "natu ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Waste Water Treatment Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Plant Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antoinetta Tornabene Rossario Cavallaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 4039 St. Augustine Lane, Dundalk, Maryland Shirley J. Cavallaro 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November Important; If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 9, 2009 4 Donation 5 Other (Specify) Dundalk, Maryland permit. F . Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease, ir complications that caused the death. Short enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OMPLICATIONS OF ADVANCED disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 I Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown unction: Affect this certificate has been signed by a by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician; The law requires 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\text{SOther (Specify)} \) HOSPICE P 1 🔲 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Lirector: After this of 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital completed filled Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) 6701 NCHAPLES ST. SUITE 4105 BALTIMOTE, MD 21204 DOBERMANIMO 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35676 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 2009 2:10 P M JOYCE ANNE CAUSEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County GILCHRIST HOSPICE CENTER Towson 8. Date of Birth Aug 26, 1933 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. 76 **Director** 241-58-3624 Usual Residence of Decedent or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director N/A 1 X Yes 2 🗆 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 403 Hollen Road **USA** of Health and Mental Hygiene. Item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ğ 1 X Never Married 2 Married 1 ☐ Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Social Security College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Supervisor Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eva Pridgen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E. Bosworth (Friend) Pinehurst Road, Baltimore, Maryland 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of Important: If it any injury or of Page 1 ō X Burial 2 Cremation 3 Removal from State Riverside Christian Ch 11/10/2009 Grifton, NC 4 Donation 5 Other (Specify) 21. Signal A f Fu al S av 6 ee Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, <u>6500 York Road, Baltimore,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant Box Ectopic pregnancy in the past 12 menths?

1 Yes 2 W No
9 Unknown Year Month 5 Other (specify) signed by the a HUS CY Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X** No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 2 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Mertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death conur f at the time, date and place, and due to the re botstale as renner bne (aloae 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) Koelf more MD 21214

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 35677

		I- For State Registrar			Certific	ate of	Death			,R	eg. No.	. 0 0	13 330
Physicia Medical Examin	n/	1. Decedent's Name (First, Middl Lavera Romand Co.	•							Date of Dea Month October 2	Day Yea 26, 2009	ir	3. Time of Death 2052 hrs
		4a. Facility Name (if not institutio Northwest Hospital	n, give street and n	umber)		4t	o. City, Town, or Randallstov		of Death		4c. County of Baltimor		nty
Funeral	- 1	5. Social Security Number	6. Sex	7. Age (Ir	yrs. last birt	hday)	If Under 1 Yea	_	_	8. Date of Bi	rth (MM/DD/YYYY		nplace (State or Foreign ntry)
Director	Į.	217-04-7812	1X M 2 F		41	Yrs.	Months Day	rs Hours	Min.	12-20-	1967		MD
any		Usual Residence of Decedent 10a. State 10b. County		100	c. City, Town	or Locatio	n					—т	10d. Inside City Limits
* .	١	MD Balt:	imore		Wood.	lawn							1 Yes 2 No
hours after death with the Maryland 'natural', or items 23a or 28a-f show Examiner must be notified at once.	Director	10e. Street and Number 7147 Bexhill Road	i				10f. Zip Code 212	44			10g. Citizen of Wh	nat Count	try?
ath with the items 23a ast be notified.		11. Marital Status	12. Was De		er in U.S.		Decedent of His						can Indian, Black,
or ited	Funeral	A-	1 Yes	Forces? 2 X	No		s, specify Cubar		, Pueno Ri	ican, etc.)		e, etc. Africa	en-American
rs afte ural",	<u>a</u>	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:		ted) 16a		Yes 2 X No		kind of wo	rk done	16b. Kind of Bu		
54 ° -	흏	Elementary/Secondary (0-12)		(1-4 or 5+)			st of working life						,
21215-0036 buld be filed within 72 hours after Mental Hygiene, marked other than "natural", event, the Medical Examine.	Completed		2			Campute	er Tech				Mercanti		enk
15-00 filed with I Hygien ed other t, the Me		17. Father's Name (First, Middle, George A. Colema	,								Maiden Surname)	
2121 hould be fil and Mental I is marked atic event,	o Be	19a. Informant's Name/Relations			19	b. Mailing	Address (Stre			e Farle	y mber, City or Tow	n, State,	Zip Code)
MD d 2 sho Ith and n 27 is	7	Jeanette Coleman				7147	Bexhill R	oad, W	oodlaw	n, Md 2	1244		
		20a. Method of Disposition 1 Disposition 2 Cremation	3 Removal	from State	20b. Place	of Disposit	ion (Name of ce er place) aI Park	metery,		Date	20c. Location -	-	
Page Page ment o									11-3-		Woodlaw		
Balt permit. Depart Impor injury								s of Facility	Wylie Doodal	Funera	l Hame P.A	of F	Baltimore Co.
Physician 23a/ Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o												Approximate Interval	
/Medical Hallure. List only one cause on each line. Hypertensive atherosclerotic cardiovascular disease.										2 /	Between Onset and Death		
xaminer		or condition resulting in death) Sequentially list conditions,	Due to (or as										
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):								
uted id ransit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	X UNPENDED	AMENDED	23a,	27,pe	rME,	g897 11	/24/0)9 TT				
3760, ificate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	10		of pregnancy	[]		Ectopi			23d. Date of Month		ay Year
P.O. Box 687 s that the death certific gned by the attending I detached for use as the	Physiciar	past 12 months? 1 Yes 2 No 9 Uni	4 Pres	gnant at tim	f -l 44-		er (Specify)			-,			
the death c the death c y the atten	ᇎ	Part II. Other significant condit		nown	ıt not resultin	o in the ur	nderlying cause	civen in Pa	art I	23e. Did	tobacco use contr	ribute to f	the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	≲	Tare in Other Significant Schan		to death 2	at not resultin	ig in the ci	identying daddo	gronmi					ably 4 🗹 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been is meral director, page 2 should I	Completed									24a. Was			topsy findings available ompletion of cause of
Reco The law icate has	티		-			-				perf	ormed?	death?	·
	υl	25. Was case referred to medica examiner?					26.Plac	e of Death	(Check or	nly one)			
of Vital ing Physician: After this certif	P P	1 🗸 Yes 2 No	Hospital: 1	Inpatient	2 Y ER/0			Other ₄		Home 5	Residence 6	Other	:
ion of \text{Itending Ph}; teath. tor: After the funeral	ation:	27. Manner of Death 1 X Natural 5 Pener 2 Accident Inve	(Mon	te of Injury hth, Day,Year	28b.	Time of In		ury at Work Yes 2	. 1	28d. Describe	how injury occur	red	
Division ital or Attendius after death.	Certification:	3 Suicide 6 Cou			/ - At home, f	am, stree	t, factory, office	building, e	tc. 2	28f. Location or Town,		er or Ru	ral Route Number, City
	Medical C		hysician: To the be miner:On the basis and manner	s of examin									
To To cor	ĕ∣	29b. Signature and title of certific					29c. Licen				29d. Date sign		
		(Calork	em			_	0.0	.M.E.			October 2	7, 2009 ———	
			ssistant Medic	al Exam	iner 11	1 Penn	Street, Balti	more, N	ID 2120	1			
Sta Registr	_	31. Date filed (Month, Day, Year)		gi ska r's	Signature	1							
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		1	For State Registrar	State of M	aryland / Depa	artment of F			giene Reg. No. 2009	35678
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of De Month	ath Day Year	3. Time of Death
	/Medic	al	Jean Brown					Novembe	er 3, 2009	6:17 PM
	Examin	er	4a. Facility Name (If not institution, given 11700 Ambleside			4b. City, Town, o		ath	Montgome	
	Funeral		5. Social Security Number 6. S	Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir		
	Director		193-32-7213	□M 2 X F	70 Yrs.	Months Days	Hours Mi	December	13, 1938 Per	nnsylvania
	pug 🔏 🗆	- H	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	f sho	. 1	Maryland Montgome	ry	100.010, 100.10.20	Potomac	2			1 ∐Yes 21X No
	the N	\overline{g}	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	h with	al D	11700 Ambleside	Drive		208	354		United St	ates
920	72 hours after death with the Maryland inatural", or items 23a or 28a-f show diest Exwaller must be incliffed at	by Fui	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ∐Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrainer must be notified at once.	Be Completed	15. Decedent's E (Specify only highest grant properties) (Secondary (0-12)	ducation ade completed) College (1-4or !	1 (Give	dent's Usual Occup kind of work done DO NOT use retired ning Boar	during most of v	vorking .ssioner	16b. Kind of Business Montgomery Government	County
þ	e filed al Hyg other	S -	17. Father's Name (First, Middle, Last		1		18. Mother's N	lame (First, Middle	, Maiden Surname)	
/lar	uld be Menta Irked Itic ev	10 E	Albert Wheatla	nd Brown			Alice	Clare S	lattery	
lar	2 sho and Is me		19a. Informant's Name/Relationship						er, City or Town, State,	
e,	and Health		Allison Cryor DiN 20a. Method of Disposition	ardo/Daugh	20b. Place of Dispo				dria, Virgi 20c. Location - City o	
nor	ages int of l t: If ite		1⊠Burial 2 ☐ Cremation 3 ☐		St. Gabr	natory or other place iel's		rember 9,	Potomac, M	
Baltin	permit. P. Departme Important any Injury once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	7	Cemetery 24 Ro M01498 Ro	2. Name and Addre	ss of Facility R	obert A.	Pumphrey F lontgomery	uneral Home/ Avenue
	Physician /Medical		23a. Part1. Einer the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	d the death. Do not en	ter the mode of dyi	ng, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death 21 months
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P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death 3	☐ Ectopic pregnand	Sy		23d. Date of d Month	elivery Day Year
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0 1	ng Pf vfter th uneral	ä	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time o ay, Year) Injury	Wor		28d. Describe	how injury occurred	
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ΣįΣ	or At after d Direc	Certification: To	4 Homicide determined	28e. Place of in	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office			Street and Number or I wn, State)	Hurai Houte Number,
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	To the within To the compl	Me	29b. Signature and title of certifier	, /	/	29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
			MAIN	hun	1	DOC	43361		November	4, 2009
	20		30. Name and address of person who Robert Siegel, M				NW Sui	te 1-200	,WashingtonD.	C. 20037
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2009	32. Regist	rar's Signature	S				

DHMH 17 Rev 1/2001

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d. X UNPENDED X AMENDED 33 , 27 , 28a-f , per ME G898 12/4/09 TT	
AMENDED AMENDED AMENDED AMENDED AMENDED FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Amended FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Vunknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of pregnancy 24e. Was an autopsy performed? 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 25b. Was case referred to medical examiner? Part II. Other significant conditions Completed AMENDED AMENDED FFEMALE: 23d. Date of delivery Month Day Amended For a part of the past 12 and	
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The state of the s	2 No
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; A Nursing Home 5 Residence 6 Other; Scer 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred	ie
Vision of the control	ute Number, (
The standard of the standard o	timore

State 31. Date filed (Month, Day, Year), Registrar

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 30, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 amend #03 PER DVR Certificate of Death Reg. No. 35680 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Roseamaria A. Catalasan October 2009 11:16 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore Baltimore 8. Date of Birth (Month, Day, Apr 11, If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Days Hours Months Min. 1 □ M 2 🖾 F Mary Land 52 216-78-3728 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Marical Exot," in must be notified at once. 1 XYes 2 ☐ No Director MD Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 1218 Steelton Avenue 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: \$ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 0 disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Bolner Lucille Denada ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Bolner/brother 1607 Harden Court Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state 21. Signal r of Funeral Pervice Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) ARCTION **Physician** MYOCARDIAI DAY /Medical Due to (or as a consequence of): Examiner LONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed HYPERTENSION Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Day Year 5 Other (specify) signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ OBESITY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should PULMONARY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 🗆 No 1 □Yes 2 A No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Seth 7444 Holabird Ave.

Dundalk, MD 21222

09-08391 Evette Clemons Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 35681

		1- For State Registrar	Cen	tificate of	Death		Reg	. No.	, 0000
Physicia	an/	Decedent's Name (First, Middle,La	•	-			Date of Death Month I	Day Year	3. Time of Death
dical Exami	ner	Evette Clemons 4a. Facility Name (if not institution, gi			4h City Tayya os	Location of Deat	October 29,	2009 4c. County of Deat	1345 hrs
)		2500 West Belvedere Av			Baltimore	Location of Death			
Funeral		5. Social Security Numbeunk 6. S	Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year		s. 8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or unk
Director			M 2XF 5	O Yrs		S Hours Will	Apr 14,		ountry)
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locat	ion				10d. Inside City Limits
* .	Ļ	MD	В	Baltimo	re				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	untry?
ith the Maryland 23a or 28a-f sho notified at once	Dir	2500 W. Belved	lere Avenue #514		21	215		USA	
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ter dea			1 Yes 2 No	1	Yes 2 X No	specify:		Specify:	black
urs afi tural'	d b	15. Decedent's Education (Specify of	or Dates: only highest grade completed)	16a. Deceder	t's Usual Occupa	tion (Give kind of	work done	6b. Kind of Business	/Industry
6 72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working life	. DO NOT use ret	ired) UTIK		unk
5-0036 ed within 7. Iygiene.	E O		unk			40 Mathada Nasa	- (5) h ((4) h (
22 E = 5 E E	Be	17. Father's Name (First, Middle, Las	π)		unk	18. Mother's Nam	e (First, Middle, Ma	liden Surname)	unk
2121; hould be fill and Mental H is marked	70	19a. Informant's Name/Relationship ((Type, Print)	19b. Mailing	Address (Stree	et and Number or	Rural Route Number	er, City or Town, State	e, Zip Code)
ore, MD Show of Health and If item 27 is ner traumatic		O.C.M.E. 20a. Method of Disposition	Lock		Penn Str		imore, MI		7
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Balt permit. Departi Import injury		21. Signature of Funeral Lervice Lice KODA d S	Mad Director					Baltimore	Street
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on a	plications that caused the death.	Do not enter t	ne mode of dying,	MD 2120 such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical	'n	Immediate use (Final disease a	_{a.} Hypertensive Cardiovas		ise				Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
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8760, rifficate be ing physici as the buri	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn		tal death 3	Ectopic pregn	ancy	23d. Date of deliver Month	Day Year
Box 68 e death certif	sician	1 Yes 2 No 9 ✔ Unknow	yn Pregnant at time of Unknown		her (Specify)			Ì	
O. Box 687 at the death certific d by the attending prached for use as the	Phy	Part II. Other significant conditions		esulting in the u	ınderlying cause (given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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ords, w requir	Completed						24a. Was an autopsy		utopsy findings available completion of cause of
Recol	E O			•			perform 1 Yes 2		es 2 No
Vital Rec ysician: The I his certificate I director, page	Bec	25. Was case referred to medical examiner?	Hitali		26.Place	of Death (Check			
Physic Price ral dire	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2	ER/Outpatient 28b. Time of I		Other Nursi	ng Home 5 Re	esidence 6 🗸 Othe	er: Scene
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Division of Vital Records, tal or Attending Physician: The law requirers after death. 14 Director: After this certificate has been silled in by the funeral director, page 2 should be	ficat	2 Accident Investiga 3 Suicide 6 Could no	ation 28e Place of Injury - 4t ho	ome, farm, stree	et, factory, office t	ouilding, etc.			ural Route Number, City
Dital o	Certification	4 Homicide determine					or Town, Sta	te)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	g		cian: To the best of my knowledger:On the basis of examination ar						
To t To t	Medi	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mo	
		Punish Rust.	10 m		O.C.	M.E.		October 30, 200	
7		30. Name and address of person who							
		Pamela E. Southall, MD	Assistant Medical Exar	-		t, Baltimore, I	MD 21201		
St Regist	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signatur	re park					

State Registrar

BABATUNDO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



MYSICIAN

MOY 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00064533

LEVINDALE

W. BELVESGRE

29d. Date signed (Month, Day, Year)

SATTIMORE MD 21215

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AVE NUE

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 3. QA M 2009 106 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Augsburg Lutheran Home Woodlawn If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🙀 F Yrs 96 08-16-1913 Norway Director 216-07-8257 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f shov Exarction rougt by notified #1 1 □Yes 2 TYNo Director Manchester Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the World Evantine rust being injury or other traumatic event, the World Evantine rust being injury or other traumatic event, the World Evantine rust being injury or other traumatic event, the World Evantine rust being injury or other traumatic event, the World Evantine rust and the page 23 and 23 and 23 and 24 and 25 U.S.A. 21102 3749 Line Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Yes, Give Specify: Completed by White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reidar Thorp Raghild Almundsen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Machester, MD 21102 Mr. Thor Dalebo - Son 3749 Line Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 11-6-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature on Funeral Service Ligensee 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 11 Unes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LZHEIME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner The law requires that the death certificate be executed and -tra Due to (or as a consequence of) burial-1 Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) □Yes 2 No P.O. signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Plac Death (Check only one) Be Hospital: 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural in 24 hours and the Euneral Director: After Mindetely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 213, SmITH 2835 mi 6 2009 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 35684 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NoV. 2009 9:05 Decarolis ам Rosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) I taly Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F Hours 85 August 1924 215-40-0085 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is anarked other than "natural", or items 23a or 28a-1 sho important: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21214 6215 Fair Oaks Avenue Italy 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 9:05 а.ш. 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 2 X No 1 XNever Married 2 Married ☐ Yes Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Crothing Seamstress 4, 2009 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ U1V1ncenzo Addolorata Lorenzo Decarolis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21214 5912 Glenoak Ave Baltimore, Maryland NOVEMBER Luciana Beach / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Balt. , Maryland 11/07/2009 Parkwood Cemetery 4 ☐ Donation 5 ☑ Other (Special tombment 21. Signature of Funeral Service 22. Name and Address of FacilityLeonard J. Ruck, inc. 5305 Harford Rd. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE DEMENTIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and I-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown ROSE DECAROLIS signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Completed nis certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Hospital or Attending Physician: The After this certificate | 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending injury death. 1 Yes Accident Investigation 2 Accident
3 Suicide
4 Homicide 24 hours after deat Funeral Director: filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one To the Within 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State

JACKIE

TIMONIUM, MD 21093

2300 DULANEY, VALLEY RD.

32. Registrar's ignature (

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35685 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Ralph William Dodd November 300 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death real If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia Age (In yrs. last bi 8. Date of Birth (Month, Day, Year) July 18,1927 Hours Months Days 1⊠M 2□F 82 235-38-9357 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Dundalk 1 ☐ Yes 2 X No Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 United States 2000 Jasmine Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ⊋Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 12 Years Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Etta Lindsey Ralph William Dodd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8817 Golden Tree Lane Essex, Maryland 21221 Diane DeLeo (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gdns. 11/5/2009 Middle River, MD 4 Donation 5 Dother (Specify) 21. Signature of Fun 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Tuha 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final wmonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an perform 1 ☐Yes 2 KNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Funeral

Director

and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

ould be f

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Maryland 21215-0036

Baltimore,

Box 68760,

Ö

of Vital Records,

Division

pe

Knows

physician and s the burial-trans as the attending use jo detached signed by the

29a. Certifier

(Check only one)

this certificate has all director, page 2 s After thi death. Director: in by the

Physician/Medical Completed Be Certification: To

To the Hospital within 24 hours a To the Funeral C

State Registrar

Medical

1 Yes 27. Manner of Death

1 Naturai 2 ☐ Accident 3 ☐ Suicide

6 Could not be determined 4 ☐ Homicide

29b. Signature and title of certifier

29c. License number

Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

VAMHCS-Pury Point MD 21902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELECIA A. SANTOS MA

31. Date filed (Month, Day, Year) 32. Registrar's Signature



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} Catherine Lillian Duvall October 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Rehab and Nursing Cente Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Aug. 30, Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XX Days Min. Year) - 1912 Months Hours Country) Director Maryland 212-03-6864 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 ☐ Yes 2XXNo MD Silver Spring Montgomery 10e, Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral death with 15115 Interlachen Drive, #302 20906 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No
If Yes, Give o. Completed by 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: White Specify: "natural", 3XXWidowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Washington Elementary/Seconday (0-12) College (1-4 or 5+) Cathedral Schools Switchboard Operator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H George Mills Rosie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau .00 Joan Utter/Daughter 14601 Sturtevant Road, Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Union Cemetery 11/7/2009 Burtonsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hours Immediate Cause (Final Ph, sician/ Hypoxemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Interstitial Pulmonary Fibrosis 3 months Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician; The law requires Severe Chronic Anorexia 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

James

31. Date filed (Month, Day, Year)

mayor mo

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rossi, M.D.

DHMH 17 Rev 7/2009

Registrar's Signature

Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D24543

3305 North Leisure World Blvd, Silver Spring, MD

29d. Date signed (Month, Day, Year)

October 30, 2009

29c. License number

09-08382 Rvan Dickens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

yan Diakono		I- For State Critificate of Registrar		Reg. N	a. 2009 3568
Physicia	n/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da	3. Time of Death
ledical Examir		Ryan Dickens	. City, Town, or Location of De	October 29, 2	4c. County of Death
	Н	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical center	Annapolis		Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Year If Under 24	Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or
Director		219-17-2857 1X M 2 F 24 Yrs. Usual Residence of Decedent	Months Days Hours	Oct 11,	1985 Foreign Country) Maryland
şuş	ŀ	10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits
	۲	Maryland Anne Arundel Dav	idsonville		1 Yes 2 X No
Maryland 28a-f show d at once.		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		1101 Captin Bell Court	21035		United States
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Memal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fish traumatic event, the Medical Examiner must be notified at once	Funeral		Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pu		14. Race - American Indian, Black, White, etc.
after call, o	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	Yes 2 X No specify:		Specify: White
hours matur Exami		during mo	s Usual Occupation (Give kind st of working life. DO NOT use		b. Kind of Business/Industry
36 iin 72 han "	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	lesman		Automobile
d with	팅	12th Sa 17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	Be (Rory Dickens		Janet Ela	
hould nd Me is man	P				r, City or Town, State, Zip Code)
MD nd 2 sho alth and m 27 is		Rory Dickens/father 1101 C	tion (Name of cemetery,	ort Davids	onville, MD 21035
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 XCremation 3 Removal from State crematory or oth	er place)	10/21/2000	Odenton Maryland
t. Pag tment tment:		4 Donation 5 Other Specify: W Arunde1 21. Junature of Funeral Service, Licensee 22. N		10/31/2009	Odenton, Maryland
Bal permi Depar Impo injur	-	Juanta R Romas M00957 1141	ame and Address of Facility	1 Home & Cr	ematory, P.A. on, Maryland 21113
Physician	┪	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardi	ac or respiratory arrest,	shock, or heart Approximate Interval Between Onset and
/Medical		fălure. List only one cause on each line. Immediate Cause (Final disease a. Hanging			Death
lammer		or condition resulting in death) Due to (or as a consequence of):			
	<u>5</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Dispasse of Injury that initiated points regulation in death). Last property regulation in death). Last			
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e exec	Medical	UNPENDED AMENDED			
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that the death certificate by the attending detached for use as I	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I		acco use contribute to the cause of death? 2 ✔ No 3 Probably 4 Unknown
ords, P.C. w requires that as been signed be	ed t			24a. Was an	24b. Were autopsy findings available
ord aw req as bee	Completed			autopsy perform	prior to completion of cause of
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Vital Rec sysician: The l this certificate l	Be	25. Was case referred to medical examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient	26.Place of Death (Ch		esidence 6 Other:
of Ving Physical After this	ို	27 Manner of Death 28a Date of Injury 28b. Time of I		28d. Describe ho	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ion:	1 Natural 5 Pending FOUND: PounD:	1 Yes 2 V N	Subject hange	ed self
isior Attender death	icat	2 Accident Investigation Oct 27, 2009 1605 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.		eet and Number or Rural Route Number, City
Divis	Certification:	3 V Suicide 6 Could not be determined (Specify) Jail/Penal		or Town, Sta 131 Jennifer Ro	ad, Annapolis, MD
= 4 m 5		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation	red at the time, date and place tion, in my opinion, death occur	e, and due to the cause(rred at the time, date an	s) and manner as stated. Indicate, and due to the cause(s)
To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		Sand I. Karathall M.D.	O.C.M.E.		October 30, 2009
		30. Name and address of person who completed cause of death (Item 23a)			
		Pamela E. Southall, MD Assistant Medical Examiner 11	1 Penn Street, Baltimo	re, MD 21201	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	arked		
Regis	trar	NOV 06 2009 Queen B. 1990			

hony Dannenn	1	State of Maryland / Department of State of Maryland / Department of Certificate of Registrar		Hygiene Reg. N	2009 356					
Physiciar dical Examin	n/	1. Decedent's Name (First, Middle,Last) Anthony Adam Danr	enmann	2. Date of Death Month Da October 31, 2	3. Time of Death 12009 1215 hrs					
		4a. Facility Name (if not institution, give street and number) 1624 Cereal Street	4b. City, Town, or Location of Dea Brooklyn		4c. County of Death N/A					
Funeral Director		5. Social Security Number 213 54 2997 6. Sex 1 Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M		9. Birthplace (State or Foreign Country) Maryland					
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc Maryland N/A Baltin			10d. Inside City Limits 1 X Yes 2 No					
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r death with the Maryland or items 23a or 28a-f show must be notified at once.		1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puer		U.S.A. 14. Race - American Indian, Black, White, etc.					
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Frygiene. Important: If item 27 is marked other unatural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at one.	Completed	6th College (1-4 or 5+)	most of working life. DO NOT use n		Home Remodeling					
21215-0 vuld be filed v Mental Hygi marked othe	8	17. Father's Name (First, Middle, Last) Joseph John Dannen		me (First, Middle, Maio Katherine	Zebron					
, MD 2 and 2 shoul ealth and N em 27 is m traumatic		Barbara Victor / sister 440	6 Belle Grove Ro	ad Balti	more, Maryland 21225					
Baltimore, permit. Pages I ar Department of Hee Important: If ite Imjury or other tr		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Removal from State Bayview	other place) Crematory 11	/03/2009 1	Baltimore, Maryland					
	-		001 Ritchie High	way Balt:	ral Service, P.A. imore, Maryland 21225 shock or heart Approximate Interval					
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxic Due to (or as a consequence of):			Between Onset and Death					
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification	3 Suicide 6 X Could not be determined Specify house	treet, factory, office building, etc.	or Town, Stat	eet and Number or Rural Route Number, City e) al St. Brooklyn, Md.					
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F \$ F 5	Me	29b. Signatura and title of certifier Would The Yould	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) November 1, 2009					
ϕ			Penn Street, Baltimore, M	D 21201						
Sta Registr	te	31. Date filed Mont 6 2009 32. Registrar Signal	,							

		-	State of N 1 - State Registrar	laryland		ertment of H Stificate of L		lental Hyg F	Jiene leg. No 2	009	35689
	Dhysisis		1. Decedent's Name (First, Middle, Last)					Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		James McKinley Dolinger			Ab Oit Town or	Location of Death	November		inty of Death	1:50 A M
1	Examin	er	4a. Facility Name (If not institution, give street and numbe Andrus House	7)		Betheso				ntgome	ry
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month Day May 12	Year)	Cour	
	Director		229-26-2452 1 M 2 □ F Usual Residence of Decedent	82	Yrs.			May 12	, 1927	West	Virginia
	yland yland		10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Ba-fsl	Director	Virginia Fairfax	Buı	cke				10- 04-0-	of What Cou	1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 9829 Wolcott Drive			10f. Zip Code 22015				d Stat	
	ms 23	Funeral	11 Marital Status 12. Was Deceder	nt Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		Race - Ameri Black, White,	can Indian,
036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, it a Marical Examination until be notified at	þ	Armed Force: 1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ If Yes, Give Ye ar or Date:] No <i>[,] [,] T</i>]	l .	1 ∐Yes 2 X No	Specify:	nican, etc.)		ecity: Wh	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind o	of Business/In	dustry
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ام 2	at Hygi other vent, i	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam			name)	
ylaı	Duld by Menta	10	Luther Dolinger					Sulliva		01-1-7	- 0-4-)
Maryland	d2sh Ith and I7 is m traum		19a. Informant's Name/Relationship (Type. Print) Diane Woodall/Daughter			ng Address (Street Wolcott					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Exemples must be notified at once.		20a. Method of Disposition 1 □ Burial 2 💆 Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	te	ce of Dispo	osition (Name of matory or other place rematory	1	Date	20c. Locati	ion - City or T	own, State Virginia
Baltir	permit. F Departmo Importar any Injur		21. Signature of Funeral Service Livensee	M01				1	_		evy Chase, Inc 1814
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death.							Approximate Interval Between Onset and Death
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ď	Examiner		Hyper	as a conseque tension							
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,0928	icate be executed physician and the burial-transit	dical	d	•							
9		Medi	IF FEMALE:								
P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant 1 Live birt	h 2 ☐ Fetal on tat time of de	leath 3	☐ Ectopic pregnand ☐ Other (specify) _			230	I. Date of deli Month	very Day Year
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_	Hospital 4 hours Funeral tely fillec	Medical Ce	29a. Certifier 1 Certifying Physician: To the bus one) 2 Medical Examiner: On the bas and manne	is of examinati	ledge, dea on and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complex	Mec				29c, Licen				signed (Monti	
			29b. Signature and title of certifier			D41	162		Nove	ember :	5, 2009
	641			Doctors	Driv	ve, Germa	ntown, Ma	aryland	2087	4	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signati	re	exted					

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I	Physici		1. Decedent's Name (First, Middle Santina		Everet			·		2. Date of Death Month November	Day Year	3. Time of Death
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		П	Good Samaritar					imore			n/a	
	Funeral Director		5. Social Security Number 214-16-5507	6. Sex 1 □ M 2 □ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yes Months Day		er 24 Hrs. Min,	8. Date of Birth (Month, Day, Jan 15,	Year) 9. Birth Cou	place (State or Foreign intry) land
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980	d within 72 hours after deeth with the Maryland Jiene. r then "naturel", or items 23a or 28a-f ehow the Medical Examinar must be ricitiled at	by	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 (X)No ve	-	Was Decedent of If Yes, specify C 1 ☐ Yes 2 🛛 N			Rican, etc.)	Black, White Specify:	
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21215-0036	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti Seamtre				Clothing	
nd	Hys Hys	BeC	17. Father's Name (First, Middle,	Last)				18. Moti	her's Name	(First, Middle, M	faiden Sumame)	
Maryland		2	Carmello	U.	Fazio				Kose		Bruno	
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		19a. Informant's Name/Relations! James W. Everet			5611	Walthe			Route Number, timore,	City or Town, State, Zi MD 21206	p Code)
Baltimore,	Page lent o nt: if ry or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Ga	Place of Dispo cemetery, crer rdens (sition (Name of natory or other p of Faith	lace)	11///		Oc. Location - City or T Overlea, M	
Ball	permit. Depertmitmoorts eny inju		21. Signature of Funeral Service	Willi	iam G.	Dau 5	Name and Add	ress of Faci ford 1	Kd.,	ard J altimor	Rucko 1762	14
,	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. King	caused the dead each line. (or as a conse	ddle	Ceres.	ying, such a	As cardiac or	respiratory arre	troke	Approximate Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions if any, leading to immediate	b Due to	(or as a conse	quence of):						
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.								
8760,	icate be executed physiclan and the burial-transit	dicai Ex	resulting in death) Last	Due to	(or as a conse	quence of):						
w.	ertifica ling ph e as th	Med	IF FEMALE:	1						-	110000000000000000000000000000000000000	
.O. Box	the death certifi by the attending packed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		einth 2 ☐ Fet eant at time of	al death 3	Ectopic pregnar Other (specify)	су			23d. Date of deliv Month	rery Day Year
Δ.	es thet Igned b	þ	Part II. Other significant conditio	ns contributing to de	eath but not re	sulting in the ur	nderlying cause	given in Part	il.	23e. Did tob	acco use contribute to	the cause of death?
COL	s been s should	ojete								24a. Was an		
		Completed								autopsy perform	prior to co	opsy findings available ompletion of cause of
Ę	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	758/0.4554		at	/	Check only one	-	
Division of	ing Ph After th uneral		27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date (Moni		28b. Time of Injury	28c. In		21		nce 6 □Other (Speci w injury occurred	fy)
	in the	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury - At h	nome, farm, stre ify)	eet, factory, offic	9	21	8f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Yammier: Ou fue ba	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date a opinion, de	and place, areath occurred	nd due to the car d at the time, da	use(s) and manner as te and place, and due t	stated. o the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	~ (1	John	N -	857	7 1)		d. Date signed (Month)	Day, Year)
	121		30. Name and address of person v	who completed caus	e of death (Ite	m 23a) (Type,	Print)	AVE	BAG	b, mo	21239	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 200	32. R	egistrar's sign	atur arke	P			ts, mo		

			for State Registrar	State of Maryla		artment of H <i>rtificate of L</i>			giene Reg. No. 2 A	00 2560
			Decedent's Name (First, Middle, Last,)				2. Date of Dea		3. Time of Death
2	Physici /Medio		Betty Elrick					Novembe	er 4, 200	09 5:00 A M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		h	4c. County	
			Heritage Harbor No. 5. Social Security Number 6. Sec.		look binkb de d	Annapo If Under 1 Year	lis If Under 24 Hrs.	8. Date of Birt		Arunde1 9. Birthplace (State or Foreign
	Funeral Director		218-28-1334	7. Age (m y/s	s. last birthday) Yrs.	Months Days	Hours Min.	March 1	y, Year)	Country) Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Anne A	rundel	Annapo	lis				1 □Yes 2X No
	or 28;	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	ath wi	ral	2700 S. Haven Roa	d		2140			USA	
altimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, if a Medical Evartirer must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates:		Vas Decedent of Hi fYes, specify Cuba I □Yes 2 AMNo	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White
15-	"natu	lete	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	16a. Dece	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of wor	king	16b. Kind of Bus	siness/Industry
212	filed within Hygiene. ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ims Adjus			U.S. Go	vernment
b	al Hygi other vent, ti	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surname	»)
ylaı	should be I and Mental s marked o umatic eve	10	Ewell M.DeNoon				Estelle	J. Joy		
lar	Sh E E	Ø.	19a. Informant's Name/Relationship (Ty			g Address (Street a			· ·	
e,	s 1 and 2. of Health a item 27 Is other tra		Willie Gregory 20a. Method of Disposition	Personal Rep		Doncaste	r Lane;	Silver S		MD 20904 City or Town, State
nor	Pages nent of int: If its iry or o		1 ⊠XBurial 2 ☐ Cremation 3 ☐ F	Dames and from Charles	cemetery, crer	natory or other place Park Ceme	e) terv 11/		voodlawn	•
atir	# 돌음을 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signable of Juneral Service Licens	a No	22	. Name and Addres	s of Facility Ste	rling As	enton Sc	hwab Witzke -
m	permi Depar Impor any ir		Me de	WHI	F	uneral Ho	me of Ca	tonsvil	le, Inc.	e, MD 21228
68760,	Physician and physician and street provided is the purial-transit	edical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	quence of): quence of):	diac card	deat	sular a	diseas _t	Interval Between Onset and Death
		Med	IF FEMALE:							
O. Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □	Ectopic pregnancy Other (specify)	<u>'</u>		23d. Date Mor	e of delivery hth Day Year
σ.	res that signed by be deta	by Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
rds	w requires s been sig should be							1 □ Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
000	law requ as been 2 shouk	Completed						24a. Was autop		Vere autopsy findings available rior to completion of cause of
<u>=</u>	sician; The law s certificate has t irector, page 2 s	E OC						perfor	med? d	eath? □Yes 2□No
Vita	ician; certific ector,	Be	25. Was case referred to medical examiner?	lo anitals		Lou		ath (Check only o		216
of	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		4 Nursing F	lome 5 Resid		
on	ding th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	28c. Injury Work	/aι ? Yes 2∐No	280. Describe n	ow injury occurre	a
Division of Vital Records,	il or Atten after deal Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre ify)			28f. Location (S City or Tow		er or Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 buts after death. To the Funeral Director: After this certificate h, completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the tin	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. Ind due to the cause(s)
9	To the withing to the complex	ž	29b. Signature and title of certifier	2	111.0	29c. License		1	3	(Month, Day, Year)
			· War O	serey	M	10	0295	7/	11/00	t/2009
			30. Name and address of person who co	mpleted cause of leath (Ite	m 23a) (Type,	Print)	ture (roft	AN MA	21114
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Sign		(7/1 //	wx, c		07/	7

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State o	f Marylan		ırtment <i>tificate</i>			and M		iene , _{eg. No.} (2009	3569	2
		1. Decedent's Name	e (First, Middle	, Last)							2. Date of Dear	h	Vaar	3. Time of Death	_
Physici /Medic		HARR	Υ	W	EIS	ENHAR	2				Month OCTOBE	Day 3 29	Year 2009.	10:10A M	
Examin	ner	4a. Facility Name (In	K MEMO	give street and nu RIAL HOS	,		4b. City, To			f Death		FF	ounty of Death REDERICI	X	
Funeral Director		5. Social Security No. 181-05-	8370	6. Sex 1	7. Age (In yrs. I 92	ast birthday) Yrs.	If Under 1 Months I		Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug 17,	Year) 191	Coui	place <i>(State or Foreign</i> ntry) sylvan i a	
and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits	-
Maryl -f sho	ţ	MD	Frede	rick		Fred	erick							1 □Yes 2√∑No	
or 28a	Funeral Director	10e. Street and Nun		1 D - 1		.	10f. Zip C		70/		1	-	n of What Cour	ntry?	_
eath w	eral		unn Orci	hard Road	edent Ever in U.S	12 1	Vas Dooder		704	ain? /Cn/	oify Vo o or No		JSA Race - Americ	an Indian	_
urs after de al", or iter	by Fun	11. Marital Status1 ☐ Never Marrie3 ☐ Widowed		Armed Fo	orces? 2 No ve		Yes, specify		Mexican Specify:	, Puerto	ecify Ye's or No- Rican, etc.)		Black, White, pecify: whi	etc.	
hin 72 hou e. an "natur a Medical E	Completed by			s Education t grade completed)		16a. Deced	lent's Usual (kind of work OO NOT use	done dur	on ring most	of worki		16b. Kind	of Business/In	dustry un	
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d be fill ental H ced oth	Be	17. Father's Name (^{.ast)} Eisenhart	=			11			(First, Middle, I atilda S		· ·		
d 2 should th and Me 7 is mark traumati	ပ္	19a. Informant's Na Louise E:	ame/Relationsh	ip (Type. Print)					d Numbe	er or Rura	ad Frede	City or T	own, State, Zip	Code)	_
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhar must be muitted at once.		20a. Method of Disp	oosition Cremation	3 □ Removal from	00	ace of Disposemetery, crem	sition (Name	of	1				tion - City or To	own, State	_
permit. F Departmo Importar any injur	1	21. Signature of Fu	/ 1	/ /:	irector	I			-		655 W.	Balt	imore S	Street	_
			rt failure. List o	complications that conly one cause on e	caused the death each line.		erthe mode			2120 cardiac d		t,	"WEDIN	Approximate Interval Between Onset and Death	_
Physician /Medical		Immediat a se (disease or condition resulting in death)	rinai n	aDue to	onaeı (or as consequ	ence of):	hear	1	ta	14	re of	100	No.		_
Examiner	e	Secuentally fist con if any, leading to im	ndtions, mediate	b. Lef	Hip (or as a consequ		ture			1.0	10 10	MAN	3		_
xecuted and Il-transit	Examiner	if any, leading to imicause. Enter Under Cause (Disease or ithat initiated events resulting in death) L		ence of):			_}	1pr	Jay 20hr	<u> </u>					
cate be executed physician and the burial-transit	dical		Į.	d						7	alan'				
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 1 □ Yes 2 9 □ Unknown	months?	1 Live	tcome of pregnal birth 2 D Fetal nant at time of de nown	death 3□	Ectopic pred Other (spec					230	d. Date of delive	ery Day Year	
uires that to signed by Id be detac	þ	Part II. Other signifi			eath but not resu	_	derlying cau		in Part I.			acco use	_	ne cause of death?	
sician: The law require: certificate has been sidirector, page 2 should b	Completed										24a. Was a autops perform	y ned?	prior to co death?	psy findings available mpletion of cause of	
ian; rtifica stor, p	Be C	25. Was case referr	ed to medical					2	6. Place	of Death	1 □Yes (Check only on	2 ⊠ No e)	1 □ Yes	2 🗆 No	_
hysic his ce I direc	70 E	examiner? 1⊠Yes 2□I	No	Hospital: 1 □	Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA	Other:	4 🗆 Nu	rsing Ho	ne 5 ☐ Reside	nce 6	☐Other (Specia	(y)	
ing Ph	ü	 Manner of Death Natural 	5 Pending		of Injury th, Day, Year)	28b. Time of Injury	_	. Injury a Work?			28d. Describe ho			1	
ttend death stor: /	cati	2 Accident 3 Suicide	investiga 6 ☐ Could no	ot bo	12009	1.00	M		s 2 X 1	1	Fell W				
al or A s after al Direc	Certification:	4 Homicide	determir		of Injury - At horning, etc. (Specify)	et, lactory, o	mice			City or Town	State		Rd Freder MD 217	
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, p	Medical (Physician: To the xaminer: On the b and man						d place,	and due to the o	ause(s) a	nd manner as s	stated.	
To th within To th comp	Me	29b. Signature and	title of certifier	1			29c. L	_icense n	number		2	9d. Date s	signed (Month,	Day, Year)	_
		•		my	_		Dr	005	5164	13		101	29/00		
		30. Name and addre	hah	ho completed caus	ne of death (Item	23a) (Type, F	Print)	De	F	-2	a cia K	MN	217	^	
I		31. Date filed (Mont												14	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Assistant Medical Examiner

egistrar's Signatur

Victor Weedn MD JD

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jane 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore Woodthome Ct. Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 🗆 M 2 🖼 Months Days Hours 86 Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Owings 1 Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21117 Woodthorne 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. 1 New Married 2 Married 1 Yes 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Private Elementary/Seconday (0-12) College (1-4 or 5+) Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Daniels Harrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teremiah Forder Ct. #8 OWINGS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State arraine Park C 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequ Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a conseque that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE:

Physician/ Medical Examiner

Physician/

Medical

Directo

Completed by Funeral

Be

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3

Examiner

Funeral

Director

Show

permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

that the death certificate be executed and burial-1 attending physician for use as the burial Physician/Medical ed by the a signed by the Certificate: To Be Completed by the Hospital or Attending Physician: The law requires has No the incorporate death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of delivery Month Day	Year				
Part II. Other significant condition	contributing to death but	not resulting in the un	iderlying	ause given in Part I. PM (1)+(9		use contribute to the cause of	
					24a. Was an autopsy performed? 1 □ Yes 2->		
25. Was case referred to medical			ck only one)				
examiner? 1 Yes 2 No	Hospital: 1 Inpatien	2 ER/Outpatient	3 🗆 D	OA Other: 4 Nursing I	lome 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death 1. Natural 5 Pending 2 Accident Investigat		28b. Time of injury	M 2	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	1 286 Place of Injury	- At home, farm, stre Specify)	et, factor	y, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Nur te)	nber,
				the time, date and place, a		and manner as stated.	manner stated

3 Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical (

only o 29b. Sian

(Month, Day

NOV 0 6 2009

DHMH 17 Rev 7/2009

cause of death (Item 23a) (Type, Print)

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene 35695 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:20 PM HERBERT FISHER 2009 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center
5. Social Security Number 6. Sex 7 Apa //p. www. leaves. Baltimore Towson 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 04-08-1933 If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Sex 1 X M 2 □ F Months Days Min 216-32-4591 76 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventual or ust be nullified at once. 1 ☐Yes 2 No Director MD BALTIMORE STEVENSON 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2120 WILTONWOOD ROAD USA 21153 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. 2 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CERTIFIED PUBLIC ACCOUNTANT ACCOUNTING 5± 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be FISHER SARAH LOUIS RUBIN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2120 WILTONWOOD ROAD, MILDRED FISHER/WIFE STEVENSON, MD 21153 Pages 1 s 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 11-05-2009 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Fun ral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eumoma Physician /Medical as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Hemolyfic and burial-trar Due to (or as a consequence of): Box 68760, the attending p IF FÉMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.0. the signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been si 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0066320 41008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANGE N 32. Registrar's Signature State Registrar

State of Maryland /	Department of Health and N	Mental Hygiene	
•	Certificate of Death	Reg. No. 2009	35696
Lauren Michelle	Gull	2. Date of Death Month Day Year October 30, 2009	3. Time of Death 1:42 P.M

/Medi-Exami

Physici

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is it if item Examination to notified a sone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	1 _ State Registrar	Certi	ificate of I	Death		Reg. No	2009	9 3	35696
an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Da	y Year		Time of Death
cal	Lauren Michell	e Gull	·		Octob		30, 2009		1:42 P.M
ier	4a. Facility Name (If not institution, give street and number)	4	lb. City, Town, or	r Location of Death	1	4c	. County of Dea	ath	
	John Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. las	A bringto alones	Ba1 If Under 1 Year	timore If Under 24 Hrs.	I a Date of Bir	th.	N/A	rthplace	(State or Foreign
	5. Social Security Number		Months Days	Hours Min.	8. Date of Bir (Month, Da 10/22	y, Year)		ountry)	-
	Usual Residence of Decedent				10/22	/ 190	50 116	11 y 10	illu
		Town or Loca	tion					10d. In	side City Limits
ţ	Maryland Anne Arundel Ba	altimo:	re					1	□Yes 2 🗓 No
irec	10e. Street and Number		10f. Zip Code			10g. Ci	tizen of What C	ountry?	
Funeral Director	705 Wellham Avenue		2	1061			U.S.A.		
ner	11. Marital Status 12. Was Decedent Ever in U.S.	13. Wa	s Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No)-	14. Race - Am Black, Wh		dian,
亞	Armed Forces? 1 Never Married 2 Married Hyes 2 No Hyes 2 No Hyes 2 No Hyes 6 No		os, specification ∃Yes 2⊠No	Specify:	o riioan, cio.)		Specific		
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:							White	
Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give kir	nt's Usual Occup nd of work done	during most of wor	king	16b. k	(ind of Busines	s/Industry	1
Ę.	Elementary/Secondary (0-12) College (1-4or 5+) 1 vear	Stud) NOT use retired lent	a)			Schoo	1	
ပ္	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maidei			
To Be	Michael A. Gull	_			ncy E. E				
F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numb	er, City	or Town, State,	Zip Code	9)
	Nancy Flynn / mother	705 W	ellham A	Avenue	Glen	Burn	ie, Mar	ylan	d 21061
	20a. Method of Disposition 20b. Plac	e of Dispositi	ion (Name of tory or other place	ce)	Date	20c. L	ocation - City o	r Town, S	State
	1Landurial 2 Li Cremation 3 Li Hemoval from State		L Cemete	11/	02/2009	Ва	ltimore	, Ma	ryland
	21. Signature of Funeral Service Licensee	22.1	Name and Addre	ss of Facility G					
	Hanne M Samuraus la	40	001 Ritc	hie High	way Bal	Ltim	ore, Ma	ryla	nd 21225
	23a/Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter	the mode of dyir	ng, such as cardiad	or respiratory	arrest,		Inte	roximate rval Between
	Immediate Cause (Final disease or condition Multisyste	em Orga	an Failu	re				Uns	et and Death
	resulting in death) Due to (or as a consequent		_						
_	Sequentially list conditions. Microvascu		ntarctio	ns				-	
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1 1-+-1	der Cernder	am a				
хап	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequer		AHLIDO	dy Syllar	onie			-	
alE									
/Medical Examiner	d								
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnanc						23d. Date of d	elivery	
cial	in the past 12 months? 4 Pregnant at time of dea		Ectopic pregnand Other <i>(specify)</i> _	:у			Month	Day	Year
Physician	9 Unknown				т.		August	19	2009
N P	Part II. Other significant conditions contributing to death but not resulting	ng in the unde	erlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the ca	use of death?
Completed by					1 🗆	Yes 2	2 K No 3□	Probably	4 Unknown
et E					24a. Was		24b. Were	autopsy f	indings available tion of cause of
E E					perf	ormed? 2 A N	death'	s 2 🗆	
Be	25. Was case referred to medical examiner?			26. Place of Dea					
2		R/Outpatient	3 □ DOA Oth	ner: 4 🗆 Nursing H	lome 5 ☐ Res	idence	6 ☐ Other (Sp	ecify)	
ü	27. Manner of Death 28a. Date of Injury 1 2 Natural 5 ☐ Pending (Month, Day, Year)	8b. Time of Injury	28c. Injui Wor	ry at k?	28d. Describe	how inju	ury occurred		
cati	2 Accident investigation			Yes 2 □No					
ŧ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location City or To	(Street a wn, Stai	nd Number or . le)	Rural Ro	ute Number,
Se	200 Cortifier 1X Contitue Division To the Least Continue Division	odno di -ii	annumed - title "	ma data III	and disaste its		(a) and mans -	20.01010	1
Medical Certification: To	29a. Certifier (Check only one) Check only one)								
Mec	29b. Signature and title of certifier		29c. Licens	se number		29d. D	ate signed (Mo	nth, Day,	Year)
	Katheune/Romas ND		RES	-000			October		
	30. Name and address of person who completed cause of death (Item 2	3a) (Type Pr	int)						
	Katherine Thomas 600 North		,	Balt	imore, N	Mary	land 21	287	
ite	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re A	1						
ar	NOV 0 6 2009 Denewa	p. 1	parket						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Day Dennis L. Goburn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Pikesville Chalkstone Drive Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Month Day 40 Months Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pikesville Baltimore 1 🗆 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 7211 Chalkstone Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 2 YCACS Housing Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (sister) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 2011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 → Burial 2 □ Cremation 3 □ Removal from State Owings Mills, MD Garrison 4 ☐ Donation 5 ☐ Other (Specify) C. Greene Funeral sucs of Funeral Service Licensee 22. Name and Address of Facility Randaulstown MD 21133 +aco 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Microvasc disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Year Pregnant at time of death Unknown

Physician/ Medical Examiner

Examiner

Physician/Medical

Completed by

Be

Certificate: To

Medical

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician/

Medical

10a. State

MD

Director

Funeral

ò

Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the should be detached is certificate has director, page 2 within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registra

10 North Greene Street

Baltimore

			For State Registrar	State of M	arylan		rtificate of	Death	wentai ny	Reg. No	000	9 35	691
п	Physici	an	1. Decedent's Name (First, Midd						Date of De Month	Da		3. Time of	Death
-	/Medic		Juanita C. G						Novemb			9:03	A ^M
	Examin	er	4a. Facility Name (If not institution					or Location of Dea	ith		. County of Deat		
	Funeval		Shady Grove Ad 5. Social Security Number			last birthday)	Rockvil If Under 1 Year		s. 8. Date of Bi	rth .	lontgome 9. Birl	hplace (State o	or Foreign
	Funeral Director		532-30-7836 Usual Residence of Decedent	1□ M 2⊠ F	7		Months Days	Hours Mir	s. 8. Date of Bi (Month, D October	9, Year)	31 Was	hingto	n
	yland now		10a. State 10b. Count	у	10c. City	y, Town or Lo	cation					10d. Inside C	ity Limits
	a-f sk	cto	Florida Palm	Beach	West	t Palm	Beach					1 🛣 Yes	2 □ No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?	
	ath wi		6500 N. Milita				33407				lted Sta		
	er de s	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13. \	Vas Decedent of f Yes, specify Cul	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, White		
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or items 23a or 28a-f show event, tre Modical Examicer must be rediffed at	þ	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	No		I∐Yes 2⊠No	Specify:				hite	
15-("natu	Completed		nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done	pation during most of we ed)	orking	16b. K	(ind of Business	Industry	
12	withir lene. than	d L	Elementary/Secondary (0-12)	College (1-4or 2	5+)		Estate B			Re	al Esta	te	
d 2	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle			neur i	Joeace D	_	ame (First, Middle				
an	should be f nd Mental I marked of Imatic eve	To B	Marvin Lamon					Elsie	Irene Co	rp			
Maryland	2 should n and Mer Is marke raumatic		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	g Address (Stree	t and Number or I	Rural Route Num	ber, City	or Town, State, .	Zip Code)	
Z	2 # C # C		Gordon T. Chi	lders/Son		17032	Briarda	le Road,	Derwood	l, Ma	ryland	20855	
nore	ages 1 al ant of Hea t: If item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		, ,		sition (Name of natory or other pla	1	mber 5,		ocation - City or		.a
Baltimore,	permit. Pages 1 Department of F important: If ite any injury or ot		4 □ Donation 5 □ Other (21. Signature of Funeral Service			Roll	en Cemeter Name and Addr Dert A. Pun	ess of Facility Tohrey Fune	ral Home/R	ockvi	er Spring. 11e, Inc.		Δ
	o		Julley	Slent	M015	48 β00	West Mont	gomery Ave	nue, Rockv	ille,	Maryland		
			√	or complications that cause st only one cause on each	d the death line.	n. Do not ent	er the mode of dy	ring, such as cardi	ac or respiratory	arrest,		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Corona			isease					4 day	S
	Examiner			Due to (or as	s a consequ	uence of):							
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	s a consequ	uence of):							
19.	cuted nd ransit	Examiner	Cause (Disease or Injury that initiated events	S .									
0,0	rificate be executed og physician and as the burial-transit	EX	resulting in death) Last	Due to (or as	s a consequ	uence of):							
68760,	ate b hysic the bu	edical		d									
9 ×			IF FEMALE:	One House suteem									
Вох	leath cer attendin I for use	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 🗆 Feta	I death 3	Ectopic pregnar Other (specify)	псу			23d. Date of de Month	-	Year
Ö	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/N	1 □ Yes 2 🔼 No 9 □ Unknown	9 Unknown	at time of u	leatii 5L	Joiner (specify)						
σ,	that ned b		Part ii. Other significant condi	tions contributing to death	but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute t	o the cause of	death?
Vital Records,	quires n sign ald be	d by	Pulmonary Em	bolism					_ 1□	Yes 2	2 ⊠ No 3 □ P	robably 4	Unknown
S	w requir	Completed							24a. Wa		24b. Were a	utopsy findings	available
æ	The lav	E O							per	opsy formed? 2 🔯 N	death?	completion of	cause of
ital		Be C	25. Was case referred to medic	al				26. Place of D	eath (Check only		0 1 10:10:	2 2 110	
f \	S S =	To B	examiner? 1 ∐ Yes 2 ⊠ No	Hospital: 1 🔀 Inpat	tient 2 🗆	ER/Outpatier	nt 3 DOA	ther: 4 🗆 Nursing	Home 5 ☐ Re	sidence	6 ☐ Other (Spe	ecify)	
n of		l ii	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of In (Month, D	jury ay, Year)	28b. Time o	28c. Inji	ury at ork?	28d. Describe	how inju	ry occurred		
<u>S</u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident inves	tigation				Yes 2 □ No					
Division	al or Att	Certification:		minod 28e. Place of Ir	njury - At ho etc. <i>(Specif</i>	ome, farm, str iy)	eet, factory, office		28f. Location City or To	(Street a wn, Stat	nd Number or R te)	ural Route Nui	mber,
	To the Hospital or I within 24 hours after To the Funeral Direction completely filled in b	Medical (ing Physician: To the bes I Examiner: On the basis and manners	of examina								(s)
	To the within To the comp	Me	29b. Signature and title of contif	er			29c. Licer	nse number		29d. D	ate signed (Mon	th, Day, Year)	
) File	L M.D	>.		Ca	6978		Nove	MEGR	1,20	09
	$\mathcal{Y}_{\mathcal{D}}$		30 Name and address of perso	n who completed cause of	death (Iten	23a) (Type,		(-	P	- J.E	0	.6.1	415
			31. Date filed (Month, Day, Yea	(CN /U-1)	trar's Signa	SLL3	SHADY	Unove	hasa,	# 20	01 1406	isvilit,	MU
	Sta Registr		NOV O	6 2009	Kul		males						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ryland		artment of H <i>tificate of D</i>		/lental Hy	giene Reg. No.	2009	35699
Phys		1/	1. Decedent's Name (First, Middle, La JERRY J		0SS				2. Date of Dea	ath		3. Time of Death
	edica mine		4a. Facility Name (if not institution, giv	e street and number)	Cen	ter	4b. City, Town, or	Location of Death	оп	4c. 6	County of Deat	timore
Fune Direct			220 12 7002		(In yrs. las 64	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da DEC 7, 1		9. Birt Cou N Y	hplace (State or Foreign untry)
ryland -f show ied at		- 1	Usual Residence of Decedent 10a. State 10b. County MD BAL	TIMORE	10c. City,	Town or Loc BAL	ation TIMORE					10d. Inside City Limits X X Yes 2 □ No
th the Ma 3a or 28a t be notif		Funeral Director	10e. Street and Number	1	-		10f. Zip Code			-	zen of What Co	
land 21215-0036 be filed within 72 hours after death with the Maryland artal Hygiene. ked other than "natural", or items 23a or 28a-f show ce event, the Medical Examiner must be notified at	1	by Fune	38 RIVER OAKS (11. Marital Status 1 \(\subseteq \text{ Never Married} \) 2 \(\frac{\frac{1}{2}}{2} \) Married	12. Was Decedent Ev Armed Forces? 1 Ves 2 XX		II	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		USA 14. Race - Ame Black, White	e, etc.
5-003(hours aft: 'natural",		Completed	3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	Year or Dates.		16a. Deced	ent's Usual Occupa	ation	ina		Specify: and of Business	WHITE
2121; within 72 giene. er than "			Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	cind of work done do NOT use retired) .ESMAN	uning most of work	ing	EYE	GLASSE	ES
Iryland ould be filed id Mental Hy marked oth		To Be	17. Father's Name (First, Middle, Last) DAVID GR	OSS				18. Mother's Nam BERNI		Maiden S	GORMAN	١
Ire, Maryle 1 and 2 should by Health and Mer item 27 is marke other traumatic			19a. Informant's Name/Relationship (g Address (Street a					
			20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	ce	metery, cren	sition (Name of natory or other place .OM MEM . P	e) ;	Date /2009		cation - City or FERSTOWN	
Baltimo permit. Page Department (Important: If any injury or	once.		21. Sign sture of Funeral Sign ce land	WW.		4	Name and Addres	301	LEVINS			
- Physicia	an/		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition				r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Medic Examin	ner		resulting in death)	Due to (or as a		ence of):						
uted Id ansit	-	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a		· ·	ICER					
760 cate be executed physician and s the burial-transit	1	ledical E)	resulting in death) Last	Due to (or as a	conseque	ence of):						1
Box 68 death certifi ne attending ed for use a		₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal	death 3	Ectopic pregnancy	у		2	23d. Date of del Month	ivery Day Year
rds, P.O. requires that the been signed by to		2	Part II. Other significant conditions	contributing to death bu	t not resu	Iting in the u	nderlying cause giv	en in Part I.				the cause of death?
Rec The law ate has		Completed				-			24a. Was autop perfo 1 \sum Yes	DSV	prior to	topsy findings available completion of cause of
Vital Visician Visician Visicertif	1	lo Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🗶 Inpatier	nt 2 🗆 E	ER/Outpatien	Lau	ace of Death (Chec er: 4 Nursing Ho		dence 6	Other (Spec	ify)
on of ending Ph eath. or: After th		Certificate:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	, 2	28b. Time of injury	28c. Injury work	rat ? Yes 2 □ No	28d. Describe h	now injury	occurred	
DIVISION Atternor all Director bed in by the			3 Suicide 6 Could not 4 Homicide determined		y - At hon (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	:	Med	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of mainer: On the basis of exa rse Practioner: To the b	amination	and/or invest	igation, in my opinio	n, death occurred a	t the time, date a	and place,	and due to the	cause(s) and manner stated.
To 1			29b. Signature and title of certified with the control of the certified of	Low	M	D.	29c. License	number 234		29d. Date	e signed (Mont	n, Day, Year)
			30. Name and address of person who	completed cause of dea				TOWSON.	MARYLA	AND	21204	
Regi	State stra	7	31. Date filed (Month Day Year) 200	9 2. Registrar	's Signa	ire fra	pl. P					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Reg	No2	0	0	9		
-						$\overline{}$	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar		Cer	tificate of	Death	Reg	Reg. No 2009 35700					
bucioi	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death				
hysici/ Medio/		Richard Augustine Heilma	n				October		8:39 A M				
Examin		4a. Facility Name (If not institution, give street and nur		4b. City, Town, o	4c. County of Dea	4c. County of Death							
		10312 Greenside Drive			Hunt Va	11ey		Baltimore	ž				
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry)				
rector		494-30-2163 ¹X□ M 2□ F	79	Yrs.	Months Days	Hours Min.	Aug 28, 1	.930 Nel	braska				
		Usual Residence of Decedent					8		22 010 200				
how #		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits				
a-f s	횫	MD Baltimore		Hunt	: Valley				1 ☐ Yes 2 No				
128	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?				
330	=	10312 Greenside Drive			21	030		USA					
IS 2	Funeral		dent Ever in U.S.	13. W			ecify Ves or No-	14. Race - Ame	erican Indian				
i ite	五	Armed For 1 □ Never Married 2 🕅 Married 1 □ Yes	ces?	If	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit					
Para Para	þ	3 ☐ Widowed 4 ☐ Divorced Year or Da	'e	1	□Yes 2 X 1No	Specify:		Specify: wh	nite				
atura en E		15. Decedent's Education		18a. Decede	ent's Usual Occup	nation	16	16b. Kind of Business/Industry					
	Completed	(Specify only highest grade completed)		(Give k	ind of work done O NOT use retire	during most of work	ing	b. Raid of Business	madou y				
‡ a	E	Elementary/Secondary (0-12) College (1	-4or 5+) 5+		teacher	-/			-11				
ent, i	ŭ	17. Father's Name (First, Middle, Last)	<u> </u>		ceacher	18 Mother's Name	e (First, Middle, Mai	private s	cnool				
ed o	Be	Oscar Emil Heilman											
nark	ဥ						Otilia Lu						
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Betty S. Heilman/spouse					al Route Number, C Hunt Vall						
m 2 her		•							21030				
or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5	20b. Plac	ce of Disposi nete <i>ry</i> , crema	ition (Name of atory or other plac	ce) ¦ [Date 20	c. Location - City or	Town, State				
ant: ury		4 ☑ Donation 5 ☐ Other (Specify)											
y Inj		21. Signature of Funeral Service Licensee Ronald So Wade, 10	Alder	22.	Name and Addre	ss of Facility	655						
트등등				DE	ate Anat	omy Board	655 W. B	altimore	Street				
		23a. Part 1. Inter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
sician		Shock, of heart failure. List only one cause on ea	icii iine.			AL INFAR			interval Between Onset and Death				
edical		resulting in death)			NYOGARIDI	M-M	CTION						
miner		Due to (or as a consequence of):											
	ē	Sequentially list conditions,	or as a consequer	nce of):									
nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
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tach	Phys	9 LI ONKNOWN	_										
gned se de	by	Part II. Other significant conditions contributing to de	ath but not resulting	ng in the und	erlying cause giv	en in Part I.	23e. Did tobac	e. Did tobacco use contribute to the cause of death?					
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s per	Completed						24a. Was an	24h Were au	utopsy findings available				
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mcau or, pe		OF Was soon referred to the Hard					1 □ Yes 2 🗹		2 □ No				
recto	Be	25. Was case referred to medical examiner? Hospital: Hospital:			Oth	26. Place of Death	(Check only one)						
al di	Certification: To	1 163 2 100	patient 2 EF			4 LI Nuising Ho	me 5 Residenc		cify)				
funei	<u>o</u>		f Injury n, Day, Year)	8b. Time of Injury	28c. injur Worl	(?	28d. Describe how i	njury occurred					
the E	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No							
n by	Ħ	determined 286, Place (of Injury - At home g, etc. <i>(Specify)</i>	e, farm, stree	t, factory, office		28f. Location (Stree City or Town, S	t and Number or Ri	ural Route Number,				
led i								,					
		29a. Certifier (Check only one) 1 Certifying Physician: To the lace of the l	nest of my knowle	edge, death o	occurred at the tir	ne, date and place,	and due to the caus	se(s) and manner a	s stated.				
the F	Medical	one) and mann	er stated.	and or mive		prinori, death occurr	eo at the time, date	ани ріасе, апо биє	to the cause(s)				
Son	≥	29b. Signature and title of certifier			29c. Licens		29d.	Date signed (Mont	h, Day, Year)				
		L/-YMD			D 00	26515		10-27-0	19				
	-	30. Name and address of person who completed cause	of death (Item 23	3a) (Type, Pr	int)				•				
		DAVID J. HARTIG M.D.	10155	YORK I	ED STE Z	DO COCK	KEYSVILLE	E MD 2	1030				
Stat	e_	31. Date filed (Month, Day, Year) 32 Re	gistrar's Signatur		Red								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32

Registrar's Signature

parked

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amend item 20c per fh 9897 11-6-09 vt
State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Ma	ryıan ——			ent of H			Reg. No	• • 2009	357	03
Physici /Medic	_	1. Decedent's Name (First, Middle, La	Muriel Y.	Hef	fner				2. Date of De	ath	^{ay} , 200 ^{Year}	3. Time of Dea 2:00 P	M
Examin		4a. Facility Name (If not institution, given Shady Grove Adver		to1		4b. City, Town, or Location of Death Rockville					4c. County of Death		
Funeral Director		5. Social Security Number 6. S			last birthday) Yrs.	1	ler 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da June 24	th ay, Year	Montgome 9. Birti Co. 25 New	hplace (State or Fo untry) York	reign
yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Li	mits
he Mar 28a-f sl	ector	Maryland Montgor	nery				Kensi	ngton			1 🗆 Y		No
th with th	ral Dir	10e. Street and Number 4418 Brookfield	Drive			10f. 2	Zip Code 20	895		-	Og. Citizen of What Country? United States		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it had call Evan in a tast be notified a once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1				cedent of Hi becify Cuba 2 No	spanic Origin? (S n, Mexican, Pueri Specify: S	pecify Yes or No to Rican, etc.) panish)-	14. Race - Amer Black, White Specify: W		
:15-(in 72 h	15. Decedent's Ed (Specify only highest gra		ji)	16a. Deced (Give life. I	dent's Us kind of v	sual Occupa vork done d use retired.	ntion uring most of wor)	king	16b. k	Kind of Business/I	ndustry		
212 ed withi ygiene. eer than	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		spe		·				vernment	
rland uld be file Mental H rked oth	To Be	17. Father's Name (First, Middle, Last) Arsenio Sosa						18. Mother's Nar Rafae	_{ne (First, Middle)} la Delga		n Surname)		
Mary nd 2 sho alth and 1 27 is ma		19a. Informant's Name/Relationship (Leslie H. Schwage									or Town, State, Z n, Maryl	ip Code) and 20895	5
Baltimore, Maryland 21215-0036 bermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: If them 27 is marked other than "natural", or any injury or other traumatic event, the Madical Examples.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. P	lace of Dispo emetery, cren			unk	Date unk.	Bet	ocation - City or T	ld. unk	
Balt permit. Depart Import any inj		21. Signatur Funeral ervice Licer		M001	98 RC	Name ber	and Addres	s of Facility Umphrey	Funeral Bethe	. Hoi	me/Bethe Cha MD 208	sda-Chevy se, Inc. 14-3501	y
Physician		23a. Part 1. Effer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused to one cause on each line a. Stroke	he death	n. Do not ent	er the m	ode of dying	g, such as cardia	or respiratory a	rrest,		Approximate Interval Betweer Onset and Deat	n
/Medical Examiner		1	Due to (or as a			a							
ansit ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a										
68760, Critificate be executed ng physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	Due to (or as a consequence of):									
	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√x No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									23d. Date of deli Month	very Day Year	
ds, P. (uires that the signed by	d by Ph	Part II. Other significant conditions o	ntributing to death but not resulting in the underlying cause given in Part I.					n in Part I.		obacco Yes 2		the cause of death	
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d	Completed								24a. Was		24b. Were au	topsy findings avail	lable
ial R n: The ficate h		05 Was assessed and 15 1							perfo	rmed? 2 □ No	death?	2 🙀 No	
f Vit	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatien	t 2 🗆	ER/Outpatien	ıt 3 🗆 I	DOA Othe	26. Place of Dear: 4 □ Nursing H			6 □Other (Spec	cify)	-
on of Vital Reding Physician: The In. After this certificate he funeral director, page	ion: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,		28b. Time of Injury		28c. Injury Work	at ?	28d. Describe				
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At ho (Specify	me, farm, stre		L	es 2□No	28f. Location (City or To	Street a wn, Stat	nd Number or Ru e)	ral Route Number,	
Div	Medical C		ysician: To the best of wher: On the basis of and manner state	examina					urred at the time,	date an	d place, and due	to the cause(s)	
To the within 2 To the complete	Me	29b. Signature and title of certifier	22			2	9c. License	number 5	7	29d. Da	ate signed (Month	n, Day, Year)	
12		30. Name and address of person who of Shahryar Davari, I		ath (Item	23a) (Type, l	Print) r Dr	ive.	<i>>U>'</i> Suite 2.	Rockvi			nd 20850	
Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar		ture	n N		······································			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - For State Registrar 35704 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Vovember Juanita L. Johnson 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner CV Maryland 5. Social Security Number renera Mate of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In rs. last birthday) **Funeral** 1 □ M 2 🖵 F Months Days Hours 436-66-7892 63 Director 10/24/1946 Louisianna Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10h. County **Funeral Director** 1 X Yes 2 □ No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 207 Plymouth Lane, Apt. C 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2√2 No Specify: Specify: Black 3 ☐ Widowed 4 🙀 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Data Entry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Be Juanita Dominick Sewell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Torronna Johnson/Son</u> 1894 Eagle Ct., Severn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 11/05/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses Zama C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Moll97 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Farlure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KARI R. DEVINO DA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

November 1,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 5, 2009 **Physician** 10:15A Josephine Dolores Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Rossville Rossville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**/X**F February 27, 1925 Maryland 218-26-5158 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sl Examinar must be mutified 1 ☐ Yes 2/17 No Funeral Director Rossville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 6600 Ridge Road 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) No 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Interest is marked other than "natural", or itel Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 XX White If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 Divorced item 27 is marked other than "nature other traumatic event, if a livedical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Research Assistant Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles J Wargo Guardian 2930 East Baltimore Street Baltimore, Maryland 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Important: If it any injury or o 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Nov. 6,2009 | Baltimore, Maryland GreenMount Crematory 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 6500 York Road Baltimore, Maryland 21212 gnature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home Inc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the rector, page 2 should be detached 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 🖵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the signature and title of certifier

State

Registrar

Name and address of person who completed cause of death (Item 23a) Type, Print) KHETERPAL 2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 7:15 AM 2009 November ET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CATONSVILLE HAVEN NURSING HOME OREST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Washington, DC **Funeral** Days Hours Months 1 ☐ M 2 🖫 🗲 -1604 Horil Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 □ Yes 2 □ No MI urnu Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other #--- any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 300 Specify: Blac ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18_Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) er MOTH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 Surial 2 □ Cremation Anne Hrundey 12/09 5 Other (Specify) rowasville 4 ☐ Donation owell 21. Signature of Frieral Service 22. Name and Address of Facility Hora ensee Ralto MD 21207 Heights Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): physician attending IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. n signed by the a Id be detached f 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been signature is 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy is certificate has director, page 2 s 1 Yes Division or Vital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2016 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes 1 🔲 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of p

son who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** Month November 4, 11:12 AM Alvin S. Jancisin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, July 23, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Hours Days 197-20-5847 81 Pennsylvania **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 20878 120 Chevy Chase Street #202 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Accountant Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Jancisin Mary Regret ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 Mary M. Ramsey/Daughter 17014 Sioux Lane, Gaithersburg, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 9. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licenses William M01173 tuyole 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Massive Cerebral Vascular Accident Sequentially list conditions, if any, leading to infime underlying cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, ≅ resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 □Yes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s performed? 1 ☐ Yes 2 🖾 No 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies , m.D D0065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 QIUFANG CHENG m.D. 9901 MEDICAL CBNTER DR. ROCKVILLE, MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS, G909, 11/3/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Rita R. 2. Date of Death **Knoblauch** November 2, 2009 Physician Rita E. Knoblauch 10:00 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air HArford Upper Chesapeake Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | New Jersey | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2√2 F 156-16-4432 83 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h County Show if of Health and Mental Hygiene.
If item 27 is marked other than "naturar", or items 23a or 28a-f shov or other traumatic event, Ite Medical Exection and to another and 1 ☐ Yes 2 No Director Harford Maryland Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1418 Beacon Court 21015 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Rita R KIf Yes, Give Year or Dates: 1 □Yes 2 XXXo Specify: White Specify 3₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be la Pauline Passalacqua Thomas Romano ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Michael Knobluach / Son 1418 Beacon Court, Bel Air, MAryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 6 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bel Air Mem. Gardens 2009 Bel Air, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—Bel Air 21. Signatu of Funeral Service Licensee (bow 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscieratic CARdio Vascular di seuse ten years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for an a nonneamente offi the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2 No ed by the a 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📝 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 【ANO 24a, Was an has autopsy performed? this certificate 1 □Yes 2 PNo director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification; To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director; filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 135522 ayo 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel AIR MARYLAND 2 NORTH Atienue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Kotofski 11705/2009 Gloria Ann M mq00:8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 1423 Decatur Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 212–40–2674 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Months Hours Min 1 □ M 245XF 67 Director 8/25/42 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygtene. ant: If flear 21 8 marked other than "natural", or items 23a or 28a-f show ant: If then traumatic event, in "not of Eraminer must be notified at ury or other traumatic event, in "note and Eraminer must be notified at MD N/A Baltimore City X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 USA 1423 Decatur Street by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. XX Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes XX No White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food/Beverage Retail Sales 0 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blinkey Stanley S. Kotofski Theresa ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Koreck / Aunt 1417 Clement Street, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot Baltimore Maryland 1 Everial 2 ☐ Cremation 3 ☐ Removal from State 11/10/2009 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ictor P. Doda, Jr. Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Flyter DISPASE YODAY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sele energiagence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 3 Ectopic pregnancy Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No 25. Was case referre to medical examiner? Be 26. Place of Death (Check onl. o. Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 No 1∐ Yeş• 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Many r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

24 hours a completely filled

Medical within 2.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

and manner stated.

29c. License number 45105 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Fort ave

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cer	rtificate of D			Reg. No. 2	09.35710			
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Louis Richard Kindle				2. Date of Dea Month Nov	2 200	Ye.ar 7:31 P ^M			
	Examir		4a. Facility Name (If not institution, give street and number) Tate Hospice House		4b. City, Town, or I	ocation of Death		4c. County o				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 2-25-19		9. Birthplace (State or Foreign Country) Maryland			
	e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State	oc. City, Town or Lo	2				10d. Inside City Limits 1 X Yes 2 □ No			
	h with th	al Dire	10e. Street and Number 2617 Sloatfield Avenue		10f. Zip Code 21223			10g. Citizen of WI	nat Country?			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marial Eventina I, ust be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Even Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of His If Yes, specify Cubar 1 □Yes 2□▼10	spanic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White			
212-0	iin 72 hoi n "natur	pletec	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			ing	16b. Kind of Bus	iness/Industry			
7170	e filed within af Hygiene. I other than ' vent, the w	Com	17. Father's Name (First, Middle, Last)	Freig	ght Handle	18. Mother's Name	e (First, Middle,		ery Ward			
lan	Mental Mental rked o	To Be	Simon William Kindle			Lucy To		iodie, walden Sumame)				
Mary	12 should be h and Mental 7 is marked c traumatic ev		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a							
re, r	of Health of Item 27 is		Betty Grambine - Daughter 20a Method of Disposition		230th Str sition (Name of matory or other place		adena,		City or Town, State			
<u> </u>	permit. Pages 1 Department of I Important: If ite any injury or of		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Loudon Pa	ark Cemete	ry 11 - 09			e, Maryland			
Ra	permit Depar Impor any in		21. Sign wite of Fund of Service Vicenses		Name and Address Hammon				me, Inc. , MD 21227			
68760,	rificate be executed 'Medical B physician and as the burial-transit	sal Examiner	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Due to (or as a condition of the cause). Due to (or as a condition of the cause). Due to (or as a condition of the cause).						Interval Between Onset and Death			
O. Box	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 2 □ No 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy☐ Other (specify)			23d. Date Mor	e of delivery hth Day Year			
ras, r.	quires that in signed by	d by Ph	Part II. Other significant conditions contributing to death but CHRONIC S35 TPUCTER				.		ibute to the cause of death? 3□ Probably 4□ onknown			
II Keco	The la ate has bage 2	Completed by	CHRINIC KIDNEY DI	SEASE			24a. Was autor perfo 1 □ Yes	rmed? p	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No			
OT VITE	ding Physician: The In. After this certificate ha funeral director, page	To Be	27. Manner of Death 28a. Date of Injury	t 2 ☐ ER/Outpatier 28b. Time of	f 28c. Injury	at Nursing Ho	ome 5 ☐ Resi	dence d othe				
Division of Vital Records,	To the Hospital or Attending Ph Within 24 hours after dea h. To the Funeral Cirector After th completely filled in by the funeral	Certification: To	Matural 5 □ Pending (Month, Day) 2 □ Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, str		? ′es 2 □No	28f. Location (. City or To		er or Rural Route Number,			
_	Hospita 24 hours Funeral stely filled	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or in	h occurred at the time	ne, date and place, binion, death occur	and due to the red at the time,	cause(s) and ma date and place, a	nner as stated. Ind due to the cause(s)			
	To the within To the comple	Med	29b. Signature and title of certifier		29c. License	number			(Month, Day, Year)			
		3	mengo, mo		D57	531		Novemb	3En 4, 1009			
			30. Name and address of Mon who completed cause of dea Mohat NCS 86 61 Vc			Te 204	mely	eville	, nd 29,02			
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 6 2009 32. Registrar	s Signature	raise							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29**,** 2009 3:45 P M October Clara Gertrude Kendall 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Summit Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 29 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min. Months Days Hours 1 □ M 2√2 F 1915 94 216-01-1073 Mar. Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 ☐ No MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 1502 Frederick Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White Specify: Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Brookhardt John Radford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Elmridge Avenue, Baltimore, MD 21229

Be of Disposition (Name of Date 20c. Location - City or Town, State <u> Theresa Kendall - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Baltimore National 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 11-2-2009 Catonsville, MD Cemetery 22 Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Funeral Service Lipen 1328 Sulphur Spring Rd., Arbutus, MD 21227 28a: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EDEMA ULMONARY Due to (or as a consequence of): CARDIAC DISEASE STAGE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown INSUFFICIEN 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

h and Mental Hygie 7 is marked other t

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any lininy or other traumatic event once.

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Examiner

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical 2 Be Completed Medical Certification: To

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 🔼 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tes 2 No 27. Manner of Death

1 Natural 2 ☐ Accident

3 🔲 Suicide

29a. Certifier (Check only

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

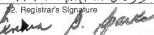
29c. License number 20065861 29d. Date signed (Month, Day, Year) 10/30/2009

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2717 HAMMONDS FERRY RD BALTIMORE, MO

State Registrar

31. Date filed (Month, Day, Year)



within 24 hours a To the Hospital

Division or Vital Records. P.O. Box 68760.

		1 - For State Registrar	,	Cer	tificate of L	Death		Reg. No.		00112
Physic	ion	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
/Medi		Anna K	lein				11		900	6.10 AM
Exami	ner	4a. Facility Name (If not institution, give street			4b. City, Town, or		ı	4c. County		
		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			nore place (State or Foreign
Funeral Director		215-78-7852		Yrs.	Months Days	Hours Min.	(Month, Da Aug. 21	y, Year)	Mary	ntry)
laryland show ed at		10a. State 10b. County	10c. City, 1	Fown or Lo	cation				1	0d. Inside City Limits
Many a-f sh	향	MD Baltimo	re C	atons	ville					1 □Yes 2🏞 No
th the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
23a ust b		1315 Ridge Road			212	228		US		
tems	Funeral	A A	as Decedent Ever in U.S. rmed Forces?	13. V	Vas Decedent of His f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert)- 14. Race - American Indian, Black, White, etc.			
If it is in the Maryland fled within the Maryland fled within 72 hours after death with the Maryland Hygiene. Whysiene. If it is medical Examiner must be notified at at the Medical Examiner must be notified at	þ	If	☐ Yes 2 🔀 No Yes, Give ear or Dates:	1	∐Yes 2⊠No	Specify:		Specify: White		
72 hc natur	etec	15. Decedent's Education (Specify only highest grade com	ppleted)	16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired,	ation luring most of wor	king	16b. Kind of Bu	siness/In	dustry
vithin ne. han "	Completed		ollege (1-4or 5+))		Ow	n Hon	ne
Hygie Hygie Ither t	ပိ	12 17. Father's Name (First, Middle, Last)		Home	maker	18. Mother's Nan	ne (First, Middle	Maiden Surnan	ne)	
should be and Mental s marked o umatic eve	To Be	Henry J. Bauman				Sara Mul			/	
2 C C 2 E	-	19a. Informant's Name/Relationship (Type. P			g Address (Street a					Code)
T and Health Health em 27 ther tr		Wayne M. Klein Son 20a. Method of Disposition			Ridge Roa	ad; Cato	Date Date	20c. Location -		own State
Pages nent of } int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	ral from State cerr	netery, cren	natory or other place	i i			•	•
nit. P. artme ortani		4 □ Donation 5 ♣ Other (Specify Ent 21. Sign three of Ineral Service Licensee)	olibine II Loud					Baltimo shton S		
Dep any		Y 118 80	77120	7 F	Name and Address uneral Ho 630 Edmor	ome of Ca	atonsvil	le, Inc	ia N	m 21228
1		23a. Part1. Enter the disease, or complication	ns that caused the death.						ic, i	Approximate Interval Between
Physician		shock, or heart failure. List only one car Immediate Cause (Final disease or condition	each line.	100	Deme	1.			1	Onset and Death
/Medical		resulting in death)	Due to (or as a consequer	of):	war.	notin				
Examiner		Sequentially list conditions b.								
p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as a consequer	nce of):					1	
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ritificate be executed ng physician and as the burial-transit			Due to (or as a consequer	nice or).						
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death ce attendir	iciar	in the past 12 months?	□Live birth 2 □ Fetal de □Pregnant at time of dea		Ectopic pregnancy Other (specify)			1	nth	Day Year
The law requires that the death ce are law requires that the death ce are not as been signed by the attending 2 should be detached for use	Physician/	9 Unknown 9	□Unknown							
as tha	by P	Part II. Other significant conditions contributions of the significant conditions contributions	ing to death but not resulting			en in Part I.	23e. Did t	obacco use cont	ribute to t	he cause of death?
w require been sign		BANCIOS LIGITIC ON O	- CASCULAT S	ar KIII 6	#E		10	Yes 2 No	3 Prol	bably 4 Unknown
e law r has be je 2 sh	Completed						24a. Was	psy	prior to co	opsy findings available impletion of cause of
	Con						perfo	ormed?	death? 1 ∐ Yes	2 No
Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospit	al·		LOthe	26. Place of Dea	th (Check only o	one)		
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or Attending Physician: ifter death. Director: After this certifica	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	ໃດ Yes 2∐No	20d. Describe	now injury occur	160	
deatl deatl cctor: y the	fica	3 Suicide 6 Could not be	e. Place of injury - At home	e, farm, str		_	28f. Location (Street and Numb	er or Rura	al Route Number,
talor s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or To	wn, State)		
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowled on the basis of examination and manner stated.	edge, death n and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as s and due t	stated. o the cause(s)
To the within 2 To the complet	Ž	29b. Signature and title of certifier	- 0		29c. License			29d. Date signe		
		rall TV	whe	- > 400	מע	4 % 3 1		N 07	2	
		30. Name and address of person who comple	Acro (L Y) S	3a) (Type,	Les. de v	ed Sufe	ivo vot	ms/ll	L M	D ZILZY

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature



		1	For State Registrar	State of Ma	aryland / [Depar <i>Certi</i>	tment of H ificate of D	ealth and M <i>leath</i>		giene (Reg. No.	2009	35713
	Physicia	n/	Decedent's Name (First, Middle, Last, Larry David						2. Date of Dea Month	ath	Year 2009	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s				4b. City, Town, or	Location of Death			County of Death	
1			Union Memorial Hospita 5. Social Security Number 6. Sec		(In yrs. last birti	hdav)	If Under 1 Year	Baltimor	8. Date of Birl 08-01-19	N/A 9. Birthplace (State or Foreign		
	Funeral Director		212-50-7093	ØM 2 □ F		Yrs.	Months Days	West	Vi rginia			
	and show dat	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Loca	ition				1	10d. Inside City Limits
	e Mary r 28a-f notifie	Director	Maryland N/A 10e, Street and Number			E	Baltimore		10a. Citiz	en of What Cour	1 X Yes 2 □ No	
	with th s 23a o lust be	Funeral	3904 Southern Avenue					21206		l	J.S.A.	
.	er death or item niner n	by Fur	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔀	? If Yes, specify Cuban, Mexican, Pue			n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - American Indian, Black, White, etc.	
003	rurs afte tural", al Exan	ted b	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.			Yes 2 X No				Specify:	White
215-	n 72 ho e. ian "na Medic	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)			(Give kir life. DO	NOT use retired)	uring most of work	ing	l	e Improver	
d 21	ed withi Hygiene other the	Be Cc	11 17. Father's Name (First, Middle, Last)	- ·			ntractor	18. Mother's Nam	e (First, Middle,			ICIU
ylan	ld be fill Mental arked d atic eve	욘	Lockard Sheffey Lamb	ert						Brown		
Mar	2 shou Ith and 27 is m		19a. Informant's Name/Relationship (Ty) Mrs. Karen Lambert -				Address (Street a	ind Number or Rura enue Ba			own, State, Zip (and 21206	Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at anone.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place o cemete	of Disposi ery, crema	ition (Name of atory or other place	e)	Date	20c. Loc	cation - City or To	
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o uc	ath. r: After ne funer	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	work	? Yes 2 \sum No	Zou. Describe	now injury	Occurred	
Division of Vital Records, P.O. Box 68760	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, fa c. (Specify)	arm, stre	et, factory, office		28f. Location (City or To		Number or Rura	al Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Phys	ner: On the basis of e	xamination and/	or investi	gation, in my opinio	on, death occurred a	at the time, date	and place,	and due to the ca	ause(s) and manner stated.
	Fo the Pwithin 24 Fo the Footbet	Me	only one) 3 Certifying Nurs	e Practioner: To the	best of my know	wledge, d	eath occurred at the 29c. License	e time, date and pla e number	ce, and due to t	he cause(s)	and manner as s e signed (Month,	tated. <i>Q</i> ay, Year)
	,		> Church	Sumas				438946			11/4	<u></u>
_	41		30. Name and address of person when Chris Jone	fompleted cause of d	Ieath (Item 23a)	(Type, Pi	rint) - Univer	sity P	arkwa	ry	Baltimor	L, MD 21218
	Sta Registr		31. Date filed (<i>Month, Day, Year</i>) NOV 0 6 2009		ar's Signature					,		
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				Pleas	e Type or	Print in E	Black Ir	ndelible	e Int	k. Ensure A	All Copie	s Are	Legible	_	
		•	For State Registrar		State o	i Maryland	Cer	tificate	of E	lealth and N Death	ленан пу	Reg. No.		9 3	5711
	Physicia	n/	1. Decedent's Name (First	t, Middle, L	,			2. Date of Death Month November					, 200 ^{Year}		e of Death
	Medic Examin	al	Richard 4a. Facility Name (if not in	stitution, g	Jame					Sr. Location of Death		County of De		:15_A ^M _	
			Stella Maris		-	7 4 7	15 2 31 35 3	If Under	OWS		1 0 D-t(D)	41-	Baltimore		
6	Funeral Director		5. Social Security Number 218–28–0781 Usual Residence of Dece		. Sex 1 □ X M 2 □ F	7. Age (In yrs. la:	Yrs.		Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	20,19	932 M	ountry) ary Land	ate or Foreign
	land fshow dat		10a. State 10b.	County		10c. City, Town or Loca									e City Limits
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	with the s 23a cust be	Funeral Director	3841 Bonview	w Ave	nue					213		109. 01.	USA		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 3 ☒ Widowed 4 □ [Armed For	2 🗌 No	1	Vas Decede f Yes, specif □ Yes 2		ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify:		1,
15-0	72 hour "natu ledical	Completed	15. (Specify or	Decedent's nly highest	s Education grade completed)		(Give		done c	ation during most of work	ing	16b. Ki	ind of Busines	s Industry	
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mor	Page 1 nent of int: If it		1 X Burial 2 Cre 4 Donation 5 D	emation 3	Removal from	State C6	emetery, cren iid Ric	natory or oth	er plac		ที่ber 2009		esville		
Baltimore, Maryland 21215-0036	permit. I Departn Importa any inju	s 10	21. sign ture of Fineral S	Service Lio	20					s of Facility uneral He ers Point				The second second	
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Division		Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investiga Could no determin	ot be 28e. Place	of Injury - At hor ng, etc. (Specify)				100 2 2 110	28f. Location (City or To			Rural Route N	lumber,
	the Hospital or thin 24 hours afte the Funeral Dir mpleted filled in	Medical	(Check 2 DM	ledical Exa	aminer: On the bas	is of examination	and/or inves	tigation, in m	y opinio	, date and place, ar on, death occurred a e time, date and place	t the time, date	and place.	, and due to th	e cause(s) and	d manner states
	To the company of the	_	29b. Signature and title o	of certifier	20.10			29c.	License	e number	7	29d. Dat	te signed (Mor	nth, Day, Year)
	KV		30. Name and address of	f person wh	no completed caus	e of death (Item	23a) (Type, F	Print)	KI	77/77			1131	10	
	10		JACKIE JON 31. Date filed (Month, Day			O DULAN		LLEY F	D.	TIMONIIN	MD 2	1093			
90	Sta Registra		NOV		09 2	Sylatian a Signati		Kel							

09-08560 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35715 Richard Theodore Loeffler Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Rick Theodore Loeffler Physician/ Month Day November 4, 2009 0758 hrs Medical Examiner Richard Theodore 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Essex 1453 Sussex Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year If Linder 24Hrs. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Months Days Hours Min Director 214-50-0636 Country)Maryland May 7, 1961 1 X M 2 48 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10h County Yes 2 X No 28a-f show s 23a or 28a-f show notified at once. Maryland Baltimore Essex Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code USA 21221 1453 Sussex Road Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status the Medical Examiner must be or items White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No Yes, Give Year Yes 2 X No specify: Specify: White Widowed 4 Divorced "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 ! If item 27 is marked other than her traumatic event, the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Mechanic Automotive 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Jean Graff Be Frederick John Loeffler III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2237 Barrison Point Road, Essex, Maryland 21221 Nancy Loeffler mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) November or other Burial 2 XCremation 3 Removal from State Bayview Crematory tant 2009 Baltimore, Maryland Donation 5 Other Specify ignatur - Funeral Service Licens Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Approximate Interval Physician Between Onset and /Madical Death Combined drug (Fluoxetine, diazepam, oxycodone) Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): intoxication Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical l per me g898 12-16-09 vt * AMENDED, 27, 28a-f, permE, 2897 XUNPENDED attending physician for use as the burial -The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Month Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed been : page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed? death? 2 No ✓ Yes 2 No 1 V Yes certificate the Hospital or Attending Physician: hin 24 hours after death. 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital director, Be examiner? Hospital: 1 Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient ER/Outpatient 3 this 1 Yes 10 No 28a. Date of Injury (Month, Day,Year) funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death 1 Natural Yes 2X No unk Pending To the Funeral Director: completely filled in by the Fd 11/4/09 Fd 7:45 am 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 1453 Sussex Rd Essex, MD (Specify) found: residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. November 5, 2009

State

31. Date filed (Month, Day, Year)

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

> bistrar's Signature ORIGINAL

111 Penn Street, Baltimore, MD 21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

		1	For State Registrar	State of Maryland /	Certificate of		Reg. No	.2009	35716
	Physicia		Decedent's Name (First, Middle, Last)	4			2. Date of Death Month Da	ay Year	3. Time of Death
-	/Medic	al	Hnne Be 4a. Facility Name (If not institution, give	II Lewis	4b. City, Town,	or Location of Death	October .	20 2009 County of Death	1140 "
	Examin		Geasons Hospi	ce Northwe		H M CZQ Ir If Under 24 Hrs.	O. Date of Birth	Kandall	Stown ace (State or Foreign
	Funeral Director		222-40-6021	7. Age (In yrs. last b	oirthday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Year March II)	1922 Nort	& Carolina
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location			10	d. Inside City Limits 1 ☐ Yos 2 ☐ No
	he Mar 28a-f st	ector	MD NI	A	Balt W	1000_	10a. C	Citizen of What Countr	
	h with t	al Dir	740 Poplar (Frove St	101. 210 0000	21216		USA	
036	be filed within 72 hours after death with the Maryland tall Hygiene. d other than "ratural", or items 23a or 28a-f show event, I'm Mcdral Eran her must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of If Yes, specify Control of Image of	f Hispanic Origin? (Speuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et	
15-0036	"natura	Completed by	15. Decedent's Edu (Specify only highest grad		ia. Decedent's Usual Occ (Give kind of work dor	cupation ne during most of worki ired)		Kind of Business/Indo	ustry
212	d withir giene. er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	House w	rite_		Domes	stic_
and	e d sal	Be	17. Father's Name (First, Middle, Last)	208		18. Mother's Name	(First, Middle, Maide	_	
Maryland	2 should be n and Menta is marked raumatic ev	P.	19a. Informant's Name/Relationship (7)	vpe. Print) 19	9b. Mailing Address (Stre	eet and Number or Rura		-	Code)
	1 and 2 Health em 27 i	1	100mas Green, 20a, Method of Disposition	Jr - Nephew L 20b. Place	of Disposition (Name of	- Grove	ot, Balt 20c.	Location - City or Tov	VID 2/2/6 vn, State
Baltimore,	Pages nent of ant: If it		1 Surial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	velt Memori	1 111	109 Ch.	esapeake	, VA
Balt	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Fineral Service Lio	Amuel &	22. Name and Ad 44000 LJ	dress of Facility Ho Derfy Heig	well Fi	eneral Berttimore	Horse, ND 21207
		V. 1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.					Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Atheroscherotic		Mar DISEASE	<u></u>		
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	e of):				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	с					
68760,	tificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	e of):				
	± 5, 6	Medical	IF FEMALE:	d					
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of delive Month	Day Year
rds, P.	w requires that the desired speen signed by the should be detached	d by Phys	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause	given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to th	ne cause of death?
Vital Records,	sician: The law rec certificate has bee irector, page 2 shoi	Completed					24a. Was an autopsy performed;	prior to cor death?	psy findings available mpletion of cause of 2 No
Vita	sician; certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:	70 July 2 7 704	Other:	h (Check only one)		pattern negric
J Of	ng Phys ter this neral di	n: To	1 Yes 2 Mo 27. Man r of Death 1 Patural 5 Pending	1 Inpatient 2 EH/	b. Time of 28c. I	njury at Nork?	ome 5 Residence 28d. Describe how in		y)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home,		1 □Yes 2 □No		and Number or Rura	al Route Number,
<u>></u>	Ital or Ars after al Director Italian Di	Certi	4 Homicide determined	building, etc. (Specity)			City or Town, St		
	e Hosp 124 hou e Fune letely fil	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my knowled liner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in the	ne time, date and place my opinion, death occu	rred at the time, date	and place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	.0		cense number 005 7 465	29d.	Date signed (Month,	
	6.1		30. Name and address of person who o	completed cause of death (Item 23	la) (Type, Print)	1 4 P - 1-10	retraining 1	MN 211	36
	Sta	ite	N'S Rapparse, M. 31. Date filed Month Day, Man	32. Registrar's Signature	cin, suit C	OU, KEISTE	1310007		
	Regist		MATIA NO COMO	prem p. 19	CALL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 per doc 8897 11-6-09 vt
State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death Marquita Lindsay 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ARQUITA PM OCTOBER 2009 5:14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKING BAYVIEW MEDICAL BALTIMORE CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Hours Director 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21206 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ō Completed by Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced "natural" Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Indust (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me y/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4rbutus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee 10 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final PULMONARY Physician EMBOLUS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Later Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the / the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year detached 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 🗆 Yes 2 🗆 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sauder MEDICAL DOCTOR RES-000 OCTOBER 30 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN MICHAEL SIGUDER MD BALTIMORE 21224 AVENUE MARYLAND 31. Date filed (Month, Day, Year) State NOV O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	laryland / D	epartmen Certificate	t of F	lealth and Death	Mental Hy	/giene		35718
	Physicia	ın/	1. Decedent's Name (First, Middle, James G. Lance	,					2. Date of D Month	eath		3. Time of Death
1	Medic Examin		4a. Facility Name (if not institution, Charlotte Hall	give street and number)	IOma			Location of Deat			County of Deat Charle	4:50 P.™
1	Funeral			6. Sex 7. Ag	je (In yrs. last birtho	lay) If Under	1 Year	If Under 24 Hrs	8. Date of B	irth	9. Birt	hplace (State or Foreign
	Director		214-18-1855 Usual Residence of Decedent	1 🖾 M 2 🗆 F	101 Y	Months	Days	Hours Min	Dec. 1	ay, Year) 5, 1	907 Ita	intry) 1 y
	land show dat	tor	10a. State 10b. County		10c. City, Town of							10d. Inside City Limits
	Mary 28a-1 notifie	Funeral Director	MD		Baltim							1 🖾 Yes 2 □ No
	ith the	ral	10e. Street and Number	"		10f, Zip					tizen of What Co	untry?
	ems 2	nue	10 East Lee Str	12. Was Decedent	Ever in U.S.		2120 ent of Hi		pecify Yes or No	US -	14. Race - Ame	ican Indian
9	or ite	by F	1 ☐ Never Married 2 ☐ Marr	Armed Forces?				spanic Origin? (S n, Mexican, Puer	to Rican, etc.)		Black, White	, etc.
93	ural", ural",	ted	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2	2 🔀 No	Specify:			Specify: Whit	.е
21215-0036	72 hou "nat	Completed		t's Education st grade completed)	i (C		k done a	ation luring most of wo	rking	16b. K	(ind of Business	ndustry
12	rithin iene.	5	Elementary/Seconday (0-12)	College (1-4 or	0+)	e. DO NOT use erator	retirea)			Lum	aber Yar	đ
b	iled w	Be	17. Father's Name (First, Middle, Li	ast)		CIGCOL		18. Mother's Na	me (First, Middle			
/lar	d be f Menta arked atic ev	욘	Joachim Lancel	otta				Elvira	Lombard	Ĺ		
, Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh			Mailing Address East Le	(Street a	and Number or Ri t reet #1	ural Route Numb 401; Bal	er, City or Ltimo	r Town, State, Zip Ore, MD	21202
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		, cemetery, New Cat	Disposition (Name crematory or ote hedral	ther plac Ceme	etery 11	Date / 7 / 2009	Balt	ocation - City or	MD
Balt	permit. Page 1 Department of Important: If it any injury or conce.		21. Signature of Funeral Service	censee	10050	22. Name and	d Addres	ss of Facility St	erling tonsvil	isht o	on Schwa Inc. ville, M	b Witzke
	Medical Examiner	jr.	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	d the death. Do not e. a consequence of)	enter the mode					-	Approximate Interval Between Onset and Death
-	ite be executed hysician and he burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Rheun	a consequence of) a consequence of)		4's					
3760	ficate g phys	/ledi		d		-						
. Box 687	Attending Physician: The law requires that the death certificate be executed ar death. **rdeath.** **ector**-Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3		y		()	23d. Date of del Month	ivery Day Year
, P.O.	ires that the signed by do be detailed	by	Part II. Other significant conditio	ns contributing to death t	out not resulting in	the underlying c	ause giv	ren in Part I.			24	the cause of death?
rds	require been si should	etec			<u> </u>							
of Vital Records,	The law I ate has t page 2 s	Completed							24a. Was auto perl 1 🗌 Yes	s an opsy formed? 2 N	prior to d	opsy findings available completion of cause of
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Che				
ίŽ	Physi this c al dire	은	1 Yes 2 No	1 Inpat	ient 2 ER/Outp			4 LV Nursing			Other (Special	fy)
o u	nding Ph tth. : After thi e funeral	cate	1 Natural 5 Pending 2 Accident Investig	g (Month, Da	y, Year)		Bc. Injury work 1 🏻		28d. Describe	how injur	y occurred	
Division	al or Atter s after dec l Director d in by the	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 280 Place of Ini	ury - At home, farm c. (Specify)	, street, factory,	, office			(Street an wn, State		al Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination and/or i	nvestigation, in n	ny opinic	on, death occurred	at the time, date	and place	e, and due to the o	ause(s) and manner state
	To th Withii To th COMP	-	29b Signatuse and title of certifier					number			te signed (Month	

mo D67814 11/4/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCISCA BRUNEY, M.D. 29449 CHARLOTTE CHARLOTTE HALL 20422

State Registrar 31. Date filed (Month, Day, Year) NOV 0 6 2009

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0953 Evelyn F. Lapoint 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Sacrit Hospiton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Min Months Days Hours 1 ☐ M 2 1 F Director 212-54-9306 89 8, Maryland Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 105 N. Delrey Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White ģ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Bowen Margaret Airey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and Item 27 is n Son Michael Lapoint 1321 Henryton Road: Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of h Important: If It any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem.Park 11/11/2009 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, Inc. Witzke 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 23a. Part 1. Enter the dise 'se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death

NCHUW n Immediate Cause (Final Myocardial Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) signed by the attending physician a I be detached for use as the burial-Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contrib 23e. Did tobacco use contribute to the cause of death? uting to death but not resulting in the underlying cause given in Part I. Completed by Fallure 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown My as thema 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗆 No 1 ☐ Yes 2 ☐ Wo To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ ot After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director; of the Funeral Director; of the formpletely filled in by the formpletely fille 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number MD D67779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saint Agres Itospital, 900 South Caton Avenue, Bultimore, Marry land, 21229 Pattani, Sanjay (4 Hani, Mar.)
31. Date filed (Month, Day, Year)
NOV 0 6 2009

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Pamela Ann Litz 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ranklin uare HOS more 8. Date of Birth (Month, Day, Year) Oct. 5, 1954 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2፟

F Months Days Hours Min. 215-68-1736 55 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 985 Phillips Place Bel Air USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 Widowed 4 Divorced Ye ar or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Antoine Nordell Gertrude (ukn) Thorwesten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory M. Litz / Husband 985 Phillips Place, Bel Air, Maryland, 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/6/09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. l/ Juc 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner rrhosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? 1 Yes 2 W No certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year)

JOHN

M.D.

SQUARE

32. Pogistrar's Signature

Ko Harathi 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 35721 1 - For State Registrar

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Extra circuit must be routiled at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ian	Steven Robert Lang					Month October	Dav	Year 1:26 A					
ical ner	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County						
iici	Hospice of Freder	ick County		Frederi	ck		Frede	rick					
	Social Security Number 6. S	57 M OF F		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	Birthplace (State or Forei Country)					
	360-44-4803	MM 2□F 59	Yrs.	Widititio Days	110010	Nov 1,	1949	Illinois					
7	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limit					
5								1 □ Yes 2 ☑ N					
To Be Completed by Funeral Director	MD Frederi 10e. Street and Number	.CK A	damsto	10f. Zip Code		10	Og. Citizen of V	What Country?					
Ö	5551 Doubs Road				21710		USA	·					
Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No-	14. Rac	ce - American Indian,					
교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 X No				to Rican, etc.)		ck, White, etc.					
þ	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:	'	□Yes 2X No	Specify:		Specify	y: white					
Be Completed	15. Decedent's Ed (Specify only highest gra	lucation (de completed)	16a. Deced	ent's Usual Occu	pation	rkina	16b. Kind of B	usiness/Industry unk					
효	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worded)								
ပိ	1 Z 17. Father's Name (First, Middle, Last)	0	C	arpenter		me (First, Middle, M	laiden Surnan	ne)					
Be	Martin Arthur L					s Melvina		16)					
2	19a. Informant's Name/Relationship (10b Mailin	a Address /Stree		ural Route Number,		State Zin Code)					
	Martin Languth/s							1009					
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State												
	cemetery crematory or other place)												
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Qther (Specify)											
	21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201												
	23a. Part1. Enter the disease, or com	plications that caused the death					est,	Approximate					
	shook, or heart failure. List only one cause on each line. Interval Between Onest and Death												
	disease or condition resulting in death) The disease of condition resulting in death) Due to (or as a consequence of):												
	mmediate Sause (Final disease or condition esulting in death) a. End Stope Giver disease or Condition Due to (or as a consequence of): Beguentially list conditions,												
Je	f any, leading to immediate Due to (or as a consequence ot):												
Examiner	cause Enter Underlying Cause (Disease or injury that initiated events c.												
	that initiated events resulting in death) Last Due to (or as a consequence of):												
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ician/Medical	IF FEMALE:	220 If you guitage of progra	2201										
ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of control 1.	al death 3 □	Ectopic pregnar Other (specify)				ate of delivery onth Day Year					
(0)	1 □Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	Jean 5L	Joiner (specify)		•							
/ Phy	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause g	iven in Part I.	23e. Did tob	acco use con	tribute to the cause of death?					
d by	Didee +	e neu	when			1 □ Ye	s 2 10	3 Probably 4 □ Unkno					
Completed						24a. Was a	n 24h	Were autopsy findings availa					
를						autops perforn	y n <u>ed</u> ?	prior to completion of cause death?					
ပိ	25. Was case referred to medical				26 Plane of Do	1 ☐ Yes 2 ath (Check only on		1 ☐ Yes 2 ☐ No					
m	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	FB/Outnatien	t 3 DOA Of	ther	Home 5 Reside		har (Specify)					
Certification: To	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe ho							
ation	1 ⊟Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	Injury		ork? ∐Yes 2 ∐No								
ific	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, stre	eet, factory, office		28f. Location (St City or Town		ber or Rural Route Number,					
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		nysician: To the best of my kno niner: On the basis of examina											
Medical	one)	and manner stated.											
2	29b. Signature and title of certifier	7		29c. Licer	nse number	2	9d. Date signe	ed (Month, Day, Year)					
	1/1/6	vouice			9/8	/ 1	1013	0/2009					
	30. Name and address of person who	completed cause of death (Item	m 23a) (Type,	Print)	11	- 0 - 0 ·	,	ed (Month, Day, Year) RO/2009 LUCOI					
	A MOW (EC 16 1600	erolle	n & hor	ie Ho	serole	en M	1001					
ate	31. Date filed (<i>Month</i> , <i>Day, Year</i>) NOV 0 6 200	32. Registrar's Signa	L.	.0 0									
rar	NU 1 U U 200	IN KENNER B	. DOLL	Kel									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2ccq October 0:10 PM **Physician** 28 Richard T. Lippy /Medical 4c. County of Death Town, ar Location of Death ame (If not institution, give street and number Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age **Funeral** Days 30, Country)
Maryland Months 1 M 2 □ F Sept 56 214-62-5624 Director Usual Residence of Decedent es 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. filem 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ed other than "natural", or items 23a or 28a-f show event, the Medical Evan inversional by nothing at 1√Yes 2□No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 USA 1925 Frederick Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed un 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Edna Cecile Chalk Raymond Edward Lippy, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1837 W. Lombard Street Baltimore, MD Diane Stout/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Stryice Licence

1. Signature of Funeral Stryice Licence

22. Signature of Funeral Stryice Licence

23. Washingtone the 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sui has cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Gruse (Final **Physician** disease or condition resulting in death) /Medical (or as a nsequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) be Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify) ed by the a 9 HInknown 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records. ð 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No r death. 2 Accident investigation al or Attend s after death I Director: / filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Cardo 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin (Month, Day, Year) NOV 0 6 2009 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of War Pand / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2009 Year Oct. 9:27 P M 31 Millie Marks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** . Year 19<u>37</u> 1 🗆 M 2 🔀 F Months Days Hours Min Feb. 10 North Carolina 213-88-7495 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 No FL Sarasota Nokomis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 109 U.S. 41 34275 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 in and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Helen Mitchell Pete Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Putty Hill Ave. Parkville, MD 21234 19a. Informant's Name/Relationship (Type, Print) Paul Demetro 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it any injury or or X Burial 2 Cremation 3 Removal from State Nov. 6, 2009 Baltimore MD Western Cemetery Donation 5 Cher (Specify) Ambrose Funeral Home uneral Service 22. Mana and Address of Facility 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ rectal adenocorcinona disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial-Physician/Medical signed by the attending place as the detached for use as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 🗻 g ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

only one

West 32. Registrar's Signature

30.-Name and address of person who completed cause of death (Item 23a) (Type, Print)

utula

Box 68760

P.O.

Division of Vital Records,

ausentown

Blud

lauson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 45 P.M. **Physician** 2009 actube William Sten Mostad /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A ag nes ealth JOVE 8. Date of Birth (Month, Day, Ye Sep. 10, If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security 7. Age (In yrs. last birthday) 1949 **Funeral** Hours 1 X M 2 ☐ F Maryland Yrs. 60 212-56-5635 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Middel Eval, the matted at once. 10c. City, Town or Location 10a. State 10b. County 1 □Yes 🙀 No Director Halethorpe Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 4230 Hollins Ferry Road, Apt. 215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 □Yes 2X No Specify Specify: \$ 3 ☐ Widowed 4 🛱 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administrative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Liv Holthe Sten William Mostad 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2550 Kensington Gardens #204, Ellicott City, MD Adam Sten Mostad - Son altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Doudon Park Cemetery 11-4-2009 Baltimore, MD 21. Signature (Funder) Service Liounce 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vaxa ma PALUMON. a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) MOStad, Milliam Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform yes 2 1 ☐ Yes 1 ☐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only orle, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 1 Tes Certification: To 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation Injury 1'Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU7353 October 31, 2009 address of pelson who completed cause of death (Item 23a) (Type, Print) caten there Bultimore, Maryland 21229

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_	_ State		artment of Health and rtificate of Death	Mental Hyg	giene Reg. No. 200	9 35725
		Registrar 1. Decedent's Name (First, Middle, Last)	Ce	runcate or Death	2. Date of Dea		3. Time of Death
Physiciar Medica		Derek Jon Meekins			November	r 2, 2009	
Examine		4a. Facility Name (if not institution, give street and num. 1960 Stanhope Rd.	per)	4b. City, Town, or Location of Deat Dundalk	th	4c. County of De Baltin	
Funeral Director		5. Social Security Number 215 73 4018 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birthday) 4 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min			Birthplace (State or Foreign Country) Lry Land
	. 1	Usual Residence of Decedent			pury ZZ	, 2005 Ma	гутапо
// Aaryland 8a-f sho tified at	rector	10b. County Maryland Baltimore	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 H No
with the last 23a or 2		10e. Street and Number 1960 Stanhope Rd.		10f. Zip Code 21222		10g. Citizen of What o	Country?
, L.9		11. Marital Status 1 💆 Never Married 2 Married 3 Widowed 4 Divorced Divorced 12. Was Decer Armed For 1 Yes If Yes, Give Year or Dat	ces? 2X No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify Whi	•
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-	(Give	dent's Usual Occupation kind of work done during most of wo O NOT use retired)	rking	16b. Kind of Busines	s Industry
/land //	8	17. Father's Name (First, Middle, Last) Jon Derek Meekins	1 7		me (First, Middle, M	Naiden Surname)	
e, Maryland and 2 should be file Health and Mental I Health and Mental I ther Traumatic eve ither traumatic eve		19a. Informant's Name/Relationship (Type, Print) Jon Derek Meekins (Fathe	r) 19b. Mailin	ng Address (Street and Number or Ru Stanhope Road, B	ural Route Number, altimore,	City or Town, State, 2 Maryland	Zip Code) 21222
imore Page 1 ar ment of He bant: If iter uny or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from 5 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer Holly Hill	sition (Name of natory or other place) Mem. Gardens 11/	Date 06/2009	20c. Location - City of Baltimore	or Town, State Maryland
Balti permit. P Departir Importa any inju	J	21. Signature of Funuil Sternice Licensee	Bi	2. Name and Address of Facility ruzdzinski Funera 407 Old Eastern A	l Home P.	.A. sex, Maryl	and 21221
Ph sician/		23a. Part 1. Enter the disease, or complications that ca shock or heart failure. List only one cause on eac Immediate Cause (Final diserse or condition	h line.	er the mode of dying, such as cardiad	17/20		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Due to (or Dequantially list conditions,	a consequence of):				
xecuted n and al-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	r as a consequence of);				
60 tte be exec hysician ar he burial-tr			r as a consequence of):				
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	iysiciari/ ivie	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of d	elivery Day Year
requires that the been signed by the should be detach	2	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.			to the cause of death?
VItal Hecords, wsician: The law requires lis certificate has been sig director, page 2 should b	niibier				24a. Was ar autops perform	y prior to ned? death?	
tal t		25. Was case referred to medical examiner?		26. Place of Death (Che	1 ☐ Yes 2 ck only one)	2 & J No. 1 □ Y	es 2 No
Physic Physic al dire	2	1 ☐ Yes 2 🎦 No Hospital: 1 ☐ Ir	patient 2 ER/Outpatien	nt 3 □ DOA Other: 4 □ Nursing F	lome 5 🛭 Reside	nce 6 Other (Spe	ecify)
or Attending Paffer death. Director: Affer tin by the funeral	care	2 Accident Investigation	injury 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
DIVISION OF tall or Attending Phes after death. al Director: After the din by the funeral Cortification.			f Injury - At home, farm, stre g, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town,	eet and Number or R State)	ural Route Number,
DIVISION OF VITAI RECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		29a. Certifier (Check conly one) 1 Certifying Physician: To the besis only one) 3 Certifying Nurse Practioner: To	of examination and/or invest the best of my knowledge, c	igation, in my opinion, death occurred a leath occurred at the time, date and pla	at the time, date and ace, and due to the d	d place, and due to the cause(s) and manner a	cause(s) and manner stated.
vitt Gor	2	29b. Signature and title of contiller M		29c. License number DY1YYY rint) 100Non- Wolfe Stee.	29	Od. Date signed (Mon	th, Day, Year)
	3	30. Name and address of person who completed cause	of death (Item 23a) (Type, P	rint)		wonger	1 3 1 2 2 5
State	3	J Kerneth J. 11. Date filed (Month, Day, Year) 32. Bet	CONCH MD (100 Nont Wolfe Stee	t ballin	ere, Mayba	W ULUF
Registrar		NOV 0 6 2009	m 1. 16	entel			

DHMH 17 Rev 7/2009

		1	For State Registrar	State of Maryland	-	artment of rtificate o		Mental Hyg	iene eg. No. 200	9 35726
	Physicia	an	1. Decedent's Name (First, Middle, Last,	Nick Marovich				2. Date of Death Month	Day Yea	
	/Medic	al	4a. Facility Name (If not institution, give			4h City Town	n, or Location of Dea		er 2, 2009	
	Examin	er	7866 Americana C		1		len Burni		Anne An	
Ī	Funeral Director		233 24 2300	x 7. Age (<i>ln yrs. l.</i> 82	ast birthday) Yrs.	If Under 1 Year Months Day			Year)	sirthplace (State or Foreign Country) Vest Virginia
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f sho	ctor	Maryland Anne	Arundel	Glen H	Burnie				1 □Yes 2 🛣 No
	th with the 23a or 28		10e. Street and Number 7866 Americana	Circle Apt.	101	10f. Zip Cod	21060	11	0g. Citizen of What 0	•
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Exc. of wr must be rediffed at	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C 1 □Yes 2 🖪 N	of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, Wh Specify:	merican Indian, nite, etc. White
5-0	72 hc	letec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual Oc kind of work do	cupation ne during most of wo tired)	orking	16b. Kind of Busines	ss/Industry
12	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		iler Mal			General	Motors
DQ 5	s 1 and 2 should be filed within 72 ho if Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, ITEL (SASIGA)	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	Maiden Surname)	
ylaı	12 should be fi h and Mental H 7 is marked ot traumatic ever	To E	unknow	n .			unkn			
Mar	12 sho		19a. Informant's Name/Relationship (T) Michael Marovich		1		eet and Number or F Ridge Ro			
<u>6</u>	1 and 2 Health tem 27 i		20a. Method of Disposition	·	1	sition (Name of matory or other p			20c. Location - City	ryland 21122 or Town, State
Baltimore, Maryland 2121	permit. Pages of Department of Important: If ite any Injury or of Once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	nemoval from State		matory or other p Cremato:		/03/2009	Baltimore	e, Maryland
3alti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licens		1. 2	2. Name and Ad	Idress of Facility (Gonce Fund	eral Servi	
	<u></u>		Carne M S	remerous						aryland 21225
	Physician /Medical		23a. Part 1. Enter the disease, or pure shock, or heart failure. Lix only o Immediate Cause (Final disease or condition resulting in death)	a. Carun	Ar	teres des	will.	ac or respiratory am	est,	Approximate Interval Between Onset and Death
7	Examiner			Due to (or s a consequence of the consequence of th	erice of):	Mullat	al			quint.
-	pd it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due lo (or as a consequ	ience of).					
MF.	ate be executed hysician and he burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
ج 8760,9	ate be hysicia he buri			d						
89 ×	ertifica ling ph e as th	Med	IF FEMALE:							
P.O. Box	that the death certific led by the attending p detached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	☐ Ectopic pregn ☐ Other (specify			23d. Date of Month	delivery Day Year
о́.	res that signed by	by Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the L	inderlying cause	given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
ords	v require been sig should b	ted b		_				1 □ Y€	es 2 /2N 0 3□	Probably 4 Unknown
of Vital Records,	law has	Completed						24a. Was a autops perform 1 ∐Yes	sv prior	
Vita	hysician: The his certificate I director, pagu	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath <i>(Check only on</i>		
of	g Phys er this eral dii	J: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time o	III 3 L DUA	4 ☐ Nursing Injury at Work?		ence 6 Other (S	Specify)
ion	Attending I death. ctor: After y the funer	atio	Natural 5 ☐ Pending investigation		Injury		Work? 1 □ Yes 2 □ No			
Division	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	ome, farm, st y)	reet, factory, offi	ice	28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or vaithin 24 hours after To the Funeral Director completely filled in b	Medical		rsiclan: To the best of my kno iner: On the basis of examina and manner stated.						
	To the within To the Comple	Me	29b. Signature and the of certifier	n nti			cense number 2664	2	29d. Date signed/(M	onth, Day, Year)
	5th		30. Name and address of person who c	ompleted cause of death (Iten	7 23a) (Type			NO Glei	1 Durie 1	W) 2106/

DHMH 17 Rev 1/2001

Registrar

		- Registrar				C	ertifica	te of	Death	}		Reg. No.	21	109	35	72
nysicia		1. Decedent's Name Kathlee		e, Last) cCarthy							2. Date of De Month Novemb	Day		Year 09	3. Time of 1:40	
/ledic amin				n, give street and nu	ımber)		4b. City	Town, o	r Location	of Death				of Death		
2111111	21	15704 J			,		_ `	nest				N	lont	gome	ry	
eral		5. Social Security N		6. Sex	7. Age (In yrs	s. last birthda	y) If Unde	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth		9. Birthp	place (State o	or Foreign
tor		413-82-4	981	1□M 2X0F	60	Yrs.	IVIOITIIS	Days	riours	IVIII I.	Sept. 16	, 1949	9		essee	
este.		Usual Residence of 10a, State	Decedent 10b. County		100.0	City, Town or	Location								Od Inside Ci	ity I ímite
any injury or other traumatic event, the Madical Evarrinet rust by multiple of once.	5					•										
	ect	Maryland 10e. Street and Num		omery	Da	arnest		ip Code				10a Citi	zon of h	Mhat Cour		
3	흡	15704 J		000				20878)			-			*	
	era	13704 J	ones r		edent Ever in	IS 1				of Marketing Biotechnology 3. Mother's Name (First, Middle, Maiden Surname) Helen Frances Gerber Number or Rural Route Number, City or Town, State, Zip Code) ne, Darnestown, Maryland 20878 Pate 2009 Bethesda, Maryland 20850 Such as cardiac or respiratory arrest, Inc. nery Avenue, Rockville, Maryland 20850 such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 months 3 months 23d. Date of delivery Month Day Year 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performeg? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 6. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 1 28d. Describe how injury occurred so 29d. Date signed (Month, Day, Year)						
	Funeral Director	1 Never Marri	ied 2□ Mar	Armed F							Rican, etc.)			ck, White,	etc.	
	5	3 Widowed		If Vac G	ive		1 ☐Yes	2 🔀 No	Specify	V:			Specify	v: Wi	nite	
	Completed	(Spec	15. Deceder	nt's Education est grade completed		16a. De	cedent's Us	ual Occup	ation	et of work	rina	16b. Ki	nd of Bu	usiness/In	dustry	
	nple	Elementary/Seco			1-4or 5+)	life	. DO NOT	use retire	d)							
	S		/F: 1.42-4-11-		•	Vic	e Pres	sider							ogy	-
	Be	17. Father's Name		McCarthy						_				ne)		
	٩					10h M	ilina Addana	- (Ctroot						Ctata Tir	- Code)	
		19a. Informant's Na		Town/Par	tner			,								
		20a. Method of Disp		-01117 - 41		Place of Dis										
		1 ☐ Burial 2 I 4 ☐ Donation		3 Removal from	i State	cemetery, c ntgomer	_		i i		•	Both	o c d	o Me	arv1 ar	a
oi		21. Signature of Fu			110											<u> </u>
8		inh	in a	Randhen	MO1	173	Robert 300 W.	A. Pi	mphre comerv	y Fun Aven	eral Hom ue. Rock	e, Koo ville.	ckvil Mar	Lie, i cyland	nc. 20850)
		23a. Part 1. Enter t	he disease, o	r complication at at	caused the de				•	-				-)	Approximat	te
n		shock, or heart failure. List only one caulled in each line. Immediate Cause (Final													Onset and I	Death
		disease or condition resulting in death) LIVET FAITURE Due to (or as a consequence of):												J mon	LIIS	
r		Cirrhosis												3 mon	ths	
4	iner	Sequentially list con if any, leading to im	nditions, mediate	Due to	(or as a conse	equence of):										
	Examiner	Cause (Disease or that initiated events resulting in death)	injury	c												
		resulting in death)	Last	Due to	(or as a conse	equence of):										
	dica			d												
	n/Medical	IF FEMALE:		23c, If yes, or	utcome of preg	nancv							ood Da	to of dollar	OF	
	.00	23b. Was deceden in the past 12	months?	1 Live	birth 2 Fe	tal death	3 Ectopic 5 Other (pregnand	СУ			1			-	Year
	Physici	1 □Yes 2 9 □ Unknown		9 □ Unk			0 11 0 11 10 1	opoony) _								
	by Ph	Part II. Other signif	ficant conditi	ions contributing to	death but not re	esulting in the	underlying	cause giv	en in Parl	t I.	23e. Did	tobacco u	ise con	tribute to t	the cause of o	death?
	q p										1 🗆	Yes 2	ሺ No	3□ Pro	bably 4 🗌	Unknown
	Completed												24b.	Were auto	opsy findings	available
	mo										_ per	formed?	İ	death?		cause of
	a)	25. Was case refer	red to medica	al					26. Pla	ce of Dea			Ш		2 🗆 140	
	O B	examiner? 1 ☐ Yes 2 🏋	No	Hospital: 1] Inpatient 2	☐ ER/Outpa	tient 3 🔲 [DOA Oth	305:				6 □Otl	her (Speci	ify)	
	L:uc	27. Manner of Deat	th 5 🗌 Pendi	/8.40	e of Injury nth, Day, Year)	28b. Time Injur		28c. Inju Wo	ry at rk?		28d. Describe	how injur	ry occur	rred		
	catic	2 Accident	invest	igation			M			□No						
	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deterr	mined 28e. Plac	e of Injury - At ding, etc. (Spe	home, farm, c <i>ify)</i>	street, facto	ory, office						ber or Run	al Route Nun	nber,
		00- 0-466-	1000000000	District Total				-1-1-1		and stand	d about he Alb		\			
	Medical	29a. Certifier (Check only one)	2☐ Medica	I Examiner: On the	basis of exami	nowledge, di ination and/o	r investigati	on, in my	ime, date opinion, d	and place leath occu	e, and due to the rred at the time	e cause(s e, date an	and m d place,	nanner as , and due t	stated. to the cause(:	s)
	Mec	29b. Signature and	title of certifie		nner stated.		2	9c. Licen	se numbe	r		29d. Da	ite signe	ed (Month.	, Day, Year)	_
		, ,	h 1 . 1	3 60					1714				_			
		30. Name and add	ress of nersor	n who completed car	use of death (It	em 23a) (Tirr	ne. Print)									
		V		ekhon, M.				B1vc	1. #1	02, I	Rockvil	le, l	Marv	land	2085	0
Sta	te	31. Date filed (Mor.	nth, Day, Year) 32.	Registrar' Sig	41	1			,		, ,				
istr	ar	MOV (0 6 200	y Charen	¥ 80. 4	70										

1. Decedent's Name (First, Middle, Last) **Physician** MINU lelpi Launa /Medical 4a. Facility Name (if not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M F 217 83 2996 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Profical Eventine that any injury or other traumatic event, the Profical Eventine that any once. 10a. State 10h County 10c. City. Town or Location **Funeral Director** MD n/a Baltimore 10e. Street and Number MD 1109 Cooks Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) Miren Russell McCoy III ပ 19a. Informant's Name/Relationship (Type. Print) Shoniece L. Reynolds (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 501

Signature of Funeral Service Licensee

amend it em 10e and 5 th 8897 11-6-09 yt and Mental Hygiene 35728 Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 03 05 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days Hours Min. 16 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2√2 No Specify: Specify: black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n/a 18. Mother's Name (First, Middle, Maiden Surname) Shoniece Latorya Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Cooks Lane Balto, Md. Date 20c. Location - City or Town, State Woodlawn Cemetery Nov. 9,2009 Balto.Md 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 11412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the shaft. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aspira

Physician /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE:

23b. Was decedent pregnant

Immediate Cause (Final

disease or condition resulting in death)

c	Due to (or as a consec	S M DL	undition	from aloly
d				
23c	. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy al death 3 ☐ Ecto	opic pregnancy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

probable

ue to (or as a consequence of):

MINOUNA

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an

autopsy berformed?

But imure, MD 21202

23d. Date of delivery

Day

Year

Month

												1 Yes	2 🗆 No	1 [∃Yes	2
	25. Was case referred	to medical				/			26.	Place of Dea	th (Ci	heck only o	one)			
ļ	examiner? 1 ☑ Yes 2 ☐ No		Hos	pital: 1 ☐ Inpatient	2 🗷	ER/Outpatient	3 🗆	DOA	Other: 4	□ Nursing H	ome	5 ☐ Resi	idence	6 ☐ Other	(Speci	fy)
I	27. Manner of Death			28a. Date of Injury	_,	28b. Time of		28c.	Injury at Work?		28d.	Describe	how inju	ry occurred	t	
ı	1 Natural	5 Pending		(Month, Day, Ye	ar)	Injury				_ [
۱	2 Accident	investigation	- 1-		-		M	-	1 ∐Yes	2 □ No						
l	3 ☐ Suicide	6 Could not be determined	1	28e. Place of Injury	At ho	me, farm, stree	t, facto	ory, of	fice		28f.	Location (Street a	nd Number	or Run	al I

Medical Certification: To Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide building, etc. (Specify) 29a. Certifier Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Completed by

Be

P.O. Box 68760,

Division of Vital Records,

State Registrar

31. Date filed (Month, Day Year NOV 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G897, 11/6709, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 3° 2009° **ESTHER** 6:50 A MATZMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth -7-1921 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Days Hours Months Min. (Month, Day Year) 88 Director 218-03-9179 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD BALTIMORE BALTIMORE 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 4203 CRESTHEIGHTS AVENUE 21215 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 X No If Yes, Give Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **ADMINISTRATOR** FEDERAL HOUSING ADMIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY MATZ SIEGEL SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a ALLAN CHARLES/NEPHEW 2425 STILL FOREST ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 11-05-2009 REISTERSTOWN, 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition) VaRIA Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the bunal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was a... autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 INNO 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a Date of injury 28c. Injury at (Month, Day, Year) work?
1 Yes 2 No Natural 5 Pending Investigation
6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

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			For State Registrar		State of Ma	aryıand	-	artment o <i>rtificate d</i>	f Health and of Death	Mentai Hy	giene Reg. No.	200	257	200
	Physicia			e (First, Middle, Las	1 11	ger				2. Date of De Month	ath Day	Year 200	3. Time of Dear	n o l AM
*	/Medic Examin Funeral Director		5. Social Security N	e View Rumber 6.8 5 9233	e street and number)	cr	as <i>t birthday)</i> Yrs.	4b. City, Town		h 1	4c. (9. Birth	place (State or For	reign
	land ow		Usual Residence o 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Lir	mits
	e Mary 3a-fsh iified	Director	Maryland	Frederic	c		Fred	erick					1 ☐ Yes 2 X]No
	with th	Dire	10e. Street and Nu					10f. Zip Coo			-	en of What Cou	intry?	
15-003b	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status	House Avenu	12. Was Decedent Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:				01701 of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.))- 1	S.A. 4. Race - Amer Black, White Specify:		
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land	rld be f fental rked o tic eve	To Be	Walter Je							a Kate Ti		Jamaniej		
, Mary	and 2 shou ealth and N 27 is mar er traumat			ame/Relationship (-	eet and Number or R dow Lane Gr				ip Code)	
Jore	ages 1 ant of He t: If item			□ Cremation 3 🔽	Removal from State			osition (Name o matory or other	•	Date		cation - City or T		
Бапптог	permit. Pa Departme Important any Injury once.			5 Other (Specification)		Cre		Cemetery 2. Name and Ad	11-0 dress of Facility eral Homes,	-2009	Gadsd	en, Alaba	ima.	
	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final on	one cause on each li	ne. \{\tau\''	Do not en	555 'lwin	Knolls Road dying, such as cardia	Columbia	1	yland 210	Approximate Interval Betweer Onset and Deatl	n h
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event- resulting in death)		Due to (or as									
	physic the bu	dica		•	d									
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ν L	es that gned to be deta	by PI	Part II. Other signi	ficant conditions	ontributing to death b					23e. Did	tobacco us	se contribute to	the cause of death	1?
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<u> </u>	ysicial is certi directo	To Be	25. Was case reference examiner?		Hospital:	ent 2 □ 1	EB/Outpatie	nt 3 □ DOA	Other:	ath <i>(Check only</i> Home 5 ☐ Res		□Other (Spec	(6)	
VISION OT	inding Phy ath. r: After thi ie funeral (ation: T	27. Manner of Dea 1 Natural 2 ☐ Accident		28a. Date of Inju (Month, Da	ury	28b. Time o Injury	of 28c.	njury at Nork? 1 □Yes 2 □ No	28d. Describe				
DIVIS	tal or Atters as after de al Directo ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	ury - At ho		reet, factory, off	ce	28f. Location City or To	(Street and wn, State)	d Number or Ru	ral Route Number,	
	Hospi 24 hour Funer etely fill	edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	nysicían: To the best niner: On the basis o and manner st	of examinat	wledge, dea tion and/or in	th occurred at the nvestigation, in	ne time, date and plac ny opinion, death occ	ce, and due to the curred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comple	Mec	29b. Signature and	I title of certifier				29c. Lic	ense number		29d. Date	e signed (Month	ı, Day, Year)	
	ΛΦ.		> 0	Le	- MD			Do	60417		11	-1-	3	
	JUV		30. Name and add	ress of person who	completed cause of	death (Item	23a) (Type,	Print)	Chasan	Dir	FV	rederin	2170 K MD	2
*	Sta Registr		31. Date filed (Mor	oth, Day, Year) 6 2009	32. Regist	rar's Signat	Sarle	Ø	Chnson	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 29 2009 Edith Willmore Miller 1:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF 93 216-03-3826 Director 10/20/1916 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Exerciner in the notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21244 7537 Betty's Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 72 hours after 1 ☐Yes 2 ☐ If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White <u>\$</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Commercial Credit Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th Typist 12 Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Suydam Edith W. Salisbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7537 Betty's Way, Windsor Mill, Maryland 21244 19a. Informant's Name/Relationship (Type. Print) John G. Miller / Son other 1 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/ 2009 Elkridge, Maryland Meadowridge Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to or as a conse uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury consequence of): Examine Due to (o s or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant Was decedent pro-in the past 12 mon 1 ☐ Yes 2 1 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.0. the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 NO director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

3. Time of Death

29d. Date signed (Month, Day, Year)

16354

ORIGINAL

900 CATON AVE BALTIMORE MD 21229

Funeral

Director the Maryland 28a-f show other traumatic event, the Medical Examiner must be notified at ò items 23a filed within 72 hours after death than "natural", or permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene important: If Item 27 Is marked other than "m any Injury or other tranmain......

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed signed by the atte be detached for page 2: Hospital or Attending Physician: this To the Funeral Director. Aft

Box 68760,

P.0

of Vital Records,

Division

02:00aM **Physician** /Medical 4c. County of Death **Examiner** Baltimore 8. Date of Birth (Month, Day, Young) July 31, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 948 New York Days Months 1X M 2 □ F 61 213-52-9423 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 2X No Halethorpe MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21227 1807 Sutton Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify. White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Local Union 19 Stage Hand 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard John O'Heir, Sr. Constance Rushmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1807 Sutton Avenue, Halethorpe, MD 21227 Elaine V. O'Heir wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-6-2009 Glen Burnie Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 21. Signature of Fuperal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CELL LUNG CANCER Immediate Cause (Final disease or condition resulting in death) YEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGNES 32. Registrar's Si

Box 68760 pe P.0. Division of Vital Records, or Attending Physician; **Physician**

Examiner

Funeral

Director

filed within 72 hours after

and Mental Hygiene.

item 27 i

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and

attending physician

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funeral director,

After this

Il Director: A

within 24 hours a

filled in by

3altimore, Maryland 21215-0036

/Medical

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Modest Event than the modest Director Maryland | Montgomery 10e. Street and Number 301 Russell Avenue, Funeral 11. Marital Status 1 Never Married 2 Married Completed by 3 ☑ Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Anthony Charles Ohge 19a. Informant's Name/Relationship (Type. Print) Brenda J. Goldsmith/Daughter permit. Pages 1 a
Department of He.
Important: If item
any injury or othe 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 ☐ Yes မှ 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) , 2009 29b. Signature and title of certifier 29c. License number N. Rahert Bischlin 04115 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 20/ RUSSELL 4VENUE HROBERT BIRSCHBACH, WAS GAITHERSBURG, NO 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Amend #9 per FH G897 11/6/09 TT/ #9perFH, G897, 11/17/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** :55 A M 12M/15 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner evindale Geriatric Center It more 7. Age (In yrs. last birthday) If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1₽M 2□ F Months Days Hours Yrs. Director EDT 30,194 0 Guyana Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 ☑ No Funeral Director bingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r 210 nited 12. Was Decedent Ever in U.S. Armed Forces? death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items:
any Injury or other traumatic event, the Medical Examiner mu
once. 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 Widowed 4 Divorced Indian Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ rmai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Court Unit 20 Abingdon MD 21009 205 Star Pointe Chery Baltimore, 20b. Place of Disposition (Name of complete vicematory or other place)

Evans Function (Name of Place)

Evans Function (Name of Complete vicematory or other place)

Part Vicematory (Style vicematory of the place)

Evans Function (Name of Place)

Part Vicematory (Style vicematory of Torent Hill, Mary land

Evans Function Chapet of Crematory Services - Pelair

Evans Function (Chapet of Crematory Services - Pelair 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EMMON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4. Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 2. No 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thours after death.

uneral Director; A
ely filled in by the fi 2☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 10064533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE 2434 W-BELVESGRE (n) 21215 BATTMERE BABATUMS 32. Registrar's Signature ASANI 31. Date filed (Month, Day, State known Registrar

	-	For State Registrar	State	of Marylar	•	rtment of tificate of		d Mental Hy	giene Reg. No. 201	09 357	35
Physicia	ın	1. Decedent's Name (First, Middle	PRETTYMA	1 N T				2. Date of Dea	ath	3. Time of De	ath
/Medica	al .	BARBARA ROLFE 4a. Facility Name (If not institution				4b. City, Town,	or Location of De	Novembe eath	er 4, 200 4c. County o		М
		1414 Bolton Str		7 4 //	1-41-4-1-3	Baltimo		les Lo Data at Bid	Nor		
Funeral Director		5. Social Security Number 142–12–8562	6. Sex 1 □ M 2√X F	7. Age (In yrs. 87	. last birthday) . Yrs.	Months Days			1922	9. Birthplace (State or F Country) New Jersey	oreign
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Loc	cation				10d. Inside City L	imits
e Mary 3a-f sh	ctor	Maryland None		Ba	altimor	e				XXYes 2	□No
with th	Dir	10e. Street and Number 1414 Bolton Str	eet			10f. Zip Code 2121			10g. Citizen of Wr USA	nat Country?	
rs after death I", or items 2:	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	12 Was Dec	cedent Ever in U orces? 2 N No silve		Vas Decedent of Yes, specify Cu □Yes 2X No		(Specify Yes or No lerto Rican, etc.)	- 14. Race Black, Specify:	- American Indian, White, etc. White	
vithin 72 hou ine. han "natural e Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)		(Give		upation e during most of w red)	vorking	16b. Kind of Bus		
I be filed w intal Hygie ed other t event, in	Be	17. Father's Name (First, Middle, I John Rolfe	Last)		Buyer			Name (First, Middle, tte Isabe	Maiden Surname	ment Store	
nd 2 should lith and Me 27 is mark r traumation	ပ	19a. Informant's Name/Relationsh Anna Yardley Pr		DTR	19b. Mailin 52 Be	g Address <i>(Stree</i> aver Riv	et and Number or	Rural Route Numbe	er, City or Town, S	State, Zip Code) 0289 ode Island	92
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nutified at once.		20a. Method of Disposition 1 Burial 2 Coremation 4 Donation 5 Other (St. 21 Signature of Foneral Skylick) 23a. Part 1. Enter the diseas, or shock, or heart failure. List	pecify) Licensee	State Gre	eenMoun 22	. Name and Add	tory Nov ress of Fa My to 500 York	chell-Wie Road Bal	Baltimore defeld Fu timore, M	e, Maryland uneral Home Maryland Approximate Interval Between	
Physician - Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	o (or as a consec	quence of):	f th	Lung			Onset and Dee	ath
th certificate be ending physicia r use as the bun	edical	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pregnar	ncv			of delivery	
t the deat by the att tached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Stood 9 ☐ Unknown		gnant at time of		Other (specify)			Mon	th Day Yea	ır
equires the	ρ Σ	Part II. Other significant conditio	ns contributing to o	death but not res	sulting in the ur	nderlying cause g	given in Part I.			bute to the cause of dea 3 • Probably 4 Unl	
in: The law reificate has be	e Completed	25. Was case referred to medical					00 Pl	1 □Yes	osy pr prmed? de 2 Euro 1	ere autopsy findings avaition to completion of cause eath? Yes 2 No	
- 0 W	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of leth Natur 5 Pending 2 Accident investig 3 Suicide 6 Could r	28a. Date (Mon	nth, Day, Year)	28b. Time of Injury	28c. Inj W	ther: 4 Nursing iury at ork? Yes 2 No	28d. Describe	dence 6 Other	d	
pital or At		4 ☐ Homicide determi	ined 28e. Plac build	ding, etc. (Spec	ify)	eet, factory, office		City or To	wn, State)	r or Rural Route Numbe	r,
the Hos hin 24 hc the Fun npletely t	Medical	one) Medical I	Examiner: On the and ma	basis of examin	nation and/or in	vestigation, in my	y opinion, death o	lace, and due to the occurred at the time,	date and place, a	nd due to the cause(s)	
T with	<	29b. Signature and title of certifier 30. Manuary ddress of person	The	LAU use of death (Ite	ē4 // m 23a) (Type,	D	2862	25	Nov. 4	(Month, Day, Year)	
	1 /	Samuel Westrick	MD 6080	Falls	Road Ba	ltimore	, Marylaı	nd 21209			

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Frank Prescimone OctoBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Hospice House Anne Arundel Linthicum 5. Social Security Number 8. Date of Birth 10-6-1935 if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex. 1 AM 2 ☐ F 7. Age (In yrs. last birthday, Days 213-32-8591 Yrs. 74 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla bepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, its "feating Exp. in remust to multified a Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Govenor's Court Apt. G 21061 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 □Yes 2 No If Yes, Give Year or Dates: Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop Laborer Dept. of Traffic/Transpor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Prescimone Sr. Frances Maida ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph F. Prescimone-son 6017 Hosta Ct., Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)
Signature of Fureral Service (Census Atlantic Crematory Nov. 3,2009 Glen Burnie MD 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road, Arbutus MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ', ovasiller disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) o ☐Yes 2☐No 9 Unknown or Attending Physician: The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2/2 No 3 Probably 4 Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No cate has by page 2 s 24a. Was an autopsy performed? Yes 2 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours are.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2:30 PM

MD

1 ☐ Yes 2 No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d, Date signed (Month, Day, Year)

Year

nes

State Registrar

29a. Certifier

(Check only one)

29b Signature and title of certifier

31. Date filed (Month, Day, Year)

30) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Medical

DHMH 17 Rev 1/200

To the Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 4 Physician/ Roger Lendall Pardoe 5:00 P.M 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Marys St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 212 16 9394 Hours 05/11/1921 88 Maryland Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Marvland Saint Marys Charlotte Hall 1 Yes 2 X No 10e. Street and Number Charlotte Hall Veterans Home Of. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 29449 Charlotte Hall Road 20622 "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Year or Dates. WW II Specify: White 3 XWidowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Meury or other traumatic event, the Me Elementary/Seconday (0-12) 7th College (1-4 or 5+) Gas Fitter B G & E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Pardoe Elsie Estelle Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5718 Phillips Street Baltimore, Maryland 21225 Margaret Stano / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite 1 X Burial 2 Cremation 3 Removal from State injury or Glen Burnie, Maryland 11/09/2009 Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, to complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final all Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** dif Sequentially list conditions, Il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Que to for as a consecuence on Exami that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown o ed by t detach cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires 3 ☐ Probably 4 ☐ Unknown Records, Completed 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Within 24 hours after deau.

To the Funeral Director: After this of a completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Dr. Avani D. Shah

NOV O

31. Date filed (Month, Day, Year)

32. Registrar's Signature

22650 Cedar Lane Court

Leonardtown, Maryland 20650

Registrar DHMH 17 Rev 1/2001

State

Parker

Box 68760, P.O. Division of Vital Records, Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

	Maryland f show	tor	10a. State 10b. County MD HAR	FORD 10c. City	y, Town or Lo					10d. Inside City Limits 1 □Yes X □ No
	the 1	rec	10e. Street and Number	FORD	بالات	10f. Zip Code		10g. (Citizen of What Co	ountry?
	h with	al Di	926 CANTERBU	RY ROAD UN	IT 1	21014			U.S.	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the fredicti Exaciliar must be rediffed at	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			nic Origin? (Specify Ye Mexican, Puerto Rican, e Specify:	s or No- tc.)	14. Race - Ame Black, White Specify:	
<u>ö</u>	hours itural"	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a Decer	lent's Usual Occupatio	n	16b.	Kind of Business	
1215	within 72 iene. than "n e ne Medik	Completed	(Specify only highest grade	e completed) College (1-4or 5+)	(Give life. L	kind of work done durii 00 NOT use retired) DITOR	ng most of working			REVENUE
and 2	d be filed ental Hygi ced other c event, II	Be	17. Father's Name (First, Middle, Last) JOHN R. PE	TZA			. Mother's Name (First,	Middle, Maid		
ary I	s 1 and 2 should be f f Health and Mental Item 27 Is marked o other traumatic eve	၉	19a. Informant's Name/Relationship (Ty		19b. Mailir	g Address (Street and	Number or Rural Route			Zip Code)
ž,	2 # C I		ROBERT PETZA/ B	ROTHER	8718	MISSION	ROAD, JESS	SUP,M	ARYLAND	20794
æ	Pages 1 and the same of Hesame I from ant. If Item arry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			eition (Name of natory or other place) EART OF	Date JESUS 11/		Location - City or	Town, State
Balti	permit. Pages Department of Important; If I any injury or once.		21. Signature of Funeral Service License	ie de la company	22	Name and Address of LILLY & 700 S - 0	ZETLER IN	IC. FU	UNERAL T.BALTI	HOME 21224 MORE.MD
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	. Do not ent					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCU Due to (or as a consequ		CARDIC) VASEU LA	2 DIC	FACE	Onset and Death
	Examiner	iner	Sequentially list conditions, if any, reauring to financiate cause. Enter Underlying Cause (Disease or injury	Dus to (or as a consequ	aence olj.					
68760, &	te be execute ysician and e burial-trans	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):			· ,		
O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attend death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ds, P.	uires that tl n signed by Id be detac	d by Ph	Part II. Other significant conditions con	stributing to death but not resu	ulting in the ur	derlying cause given i	Part I. 23	e. Did tobacc		o the cause of death?
al Records,	he law req e has beer ige 2 shou	mplete						a. Was an autopsy performed	death?	utopsy findings available completion of cause of
Ø	an; T rtificat tor, pa	1 7 7	25. Was case referred to medical			26	. Place of Death (Check	Yes 2	No 1 □Ye	s 2□No
>	nysici nis cel direc	lo Be	examiner?	lospital: 1₅□ Inpatient 2□	ER/Outpatier	Othor	4 Nursing Home 5[6 ☐ Other (Spe	ecify)
Division of Vit	nding Pl ath. r: After tl e funeral	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work?	28d. De	scribe how in	jury occurred	
Divis	al or Atters after dear l Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	28f. Loc City	ation (Street or Town, St	and Number or F ate)	iural Route Number,
	To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this certiful completely filled in by the funeral director.	Medical C		sician: To the best of my knowner: On the basis of examination and manner stated.						
	within To the comp	Me	29b. Signature and title of certifier	100	<u>.</u>	29c. License nu		1	Date signed (Mon	_
	10		y wy wook		00 \ /T	1200	60560 - RD #	100	VEMBER	25,2009
	5		PANKAT CHETER	completed cause of death (Item	PHIL	Porphin	- RD #	Zoy,	BAUTIN	-ort, mp
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture					
DHN	/IH 17 Rev 1/2	001								
					OR	IGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, **Physician** AUrela 260 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner mo Baltonore Soutement f Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct 25, . Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months Hours Min. ^{Year)} 2009 1 □ M 2 🛛 F Maryland Director infant Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once. MD 1 ☐ Yes 2 No Washington Director Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21738 Academy Terrace 21740 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennifer Payne Jason Payne ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 S. Green Street Baltimore, MD University of Maryland Med Ctr 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 \$\Other (Specify) in state 21. Signature of Euneral Service Licensee Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** monare disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner reme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I has been signed by the are 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate har funeral director, page. 2 No 1 Nes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Year 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cau

ynthia

NOV 06

e of death (Item 23a) (Type, Print)

29c. License number

S. GREENES

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2009 6:20 Рм Beatrice Mary Pettit Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Auq. 4, 1921 ^{Country)}Maryland 215-14-9772 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2525 Pot Spring Road #326S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. þ 1 \square Never Married 2 \square Married 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 N Widowed 4 Divorced white Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph F. Soler Rose M. Kaspar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son-in-law 4026 Holly Knoll Drive; Glen Arm, MD 21057 David C. Page 20a. Method of Disposition
1 □ Burial 2 ☑ Gremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 D Other (Specify) Hilltop Service Corp. 11/6/09 Towson, MD 21. Signature of Fun-1050 York Road 22. Name and Address of Facility MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a, Part 1, Enter the disease, or complications $\mathbf{z}_{ ext{t}}$ caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) BLADDER CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Year Pregnant a 5 Other (specify) Pregnant at time of death 1 Yes 2 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🔲 No Yes 2 to No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: $_4$ \square Nursing Home 5 \square Residence 6 f X Other (Specify) f HOSPICEHospital: ည 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniurv 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

NOVEMBER

BEATRICE

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

less of person who completed cause of death (Item 23a) (Type, Print)

JONES.

Date filed (Month; Day, Year)

CRNP

DHMH 17 Rev 1/2001 OCME 2006

O

State Registra

To the

2 1

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Year)

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 4, 2009

30. Name and address of person who completed cause of death (item 23a)

and manner stated

Assistant Medical Examiner

2. Registrar's Sign

Box 68760 attending physician P.O. á Division of Vital Records, has certificate this After 1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3, **Physician** 2009 Ann Tolbert Richardson November 6:52A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AA Medical Center Annapolis AA County Birthplace (State or Foreign Country) D . C . 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗷 F 89 578-12-3261 Director Usual Residence of Decedent 10b. County Montgomery 10c. City, Town or Location Bethesda 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 20817 5825 Conway Rd. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. White permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, Ite Me-Steal Examinate one. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Anderson Tolbert Lucy Jane Elizabeth Lampkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Richardson/Son 1003 Baltimore Ave. West River, MD 20778 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. Nov. 5 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 2009 MOISS 22. Name and Address of Fac@AFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee Reben 8717 Green Pastures Dr. Balto, MD 21286 Moon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARETION **Physician** /Medical HEART DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 3 Probably 4 Unknown Completed PEDEMI 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: A
inletely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and tipe of certifier D0063146 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIGITAL DR 31. Date filed (Month, Day, Year, Redistrar's Signature State NOV 0 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** November 4, 3:55 P^{M} Dennis Orman Rippeon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing and Wellness Center Montgomery Rockville 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, May 12, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 X M 2 □ F Months Days Hours 1947 62 Director 217-44-4820 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Darnestown Montgomery should be filed within 72 hours after death with the and Mental Hygiene. 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 14931 Springfield Road 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1970-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 2 3 Widowed 4 Divorced 1975 Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Chief Operations Officer Automobile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alta Mae Deadrick Orman Z. Rippeon ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any Injury or other traun once. Priscilla Ann Rippeon/Wife 14931 Springfield Road, Darnestown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 2009 10, Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Funeral Home, Rockville, Inc. Mullian M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 -a, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 Year Severe Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ ficate has been signs, page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No certificate 1 ☐ Yes 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 5, 2009 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 2401 Research Blvd. #330, Rockville, Maryland Anurita Mendhiratta, M.D. 31. Date filed (Month, Day, Year 32. Registrar's Signature MOY 0 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State	State	of Mary	land / Depa	artment of F ctificate of	Health and N	Mental Hyg	iene g. No. 21	009	35745			
			Registrar 1. Decedent's Name (First, Middle,	Last)			imoate or	Death	2. Date of Deat			3. Time of Death			
E	Physicia /Medic		Mary Sulliva	n Robert	S				Novembe:	r 4, 2	0ď§ªr	1:00 A M			
	Examin		4a. Facility Name (If not institution,	-	umber)		-	r Location of Death			ty of Death				
_			National Luther 5. Social Security Number	an Home	7 Age (Ir	yrs. last birthday)	Roc	kville	8. Date of Birth	1	gomer) place (State or Foreign			
Н	Funeral Director		577-24-4338	1 □ M 2 🔀 F	86		Months Days	Hours Min.	8. Date of Birth (Month, Day, March 2	,1923	Mass	achusetts			
	pu ,		Usual Residence of Decedent		140	O:1- T					1	0d. Inside City Limits			
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	ems a	Funeral	11. Marital Status	12. Was Dec		in U.S. 13.	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		ace - Americ				
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9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	ted t	15. Decedent	s Education		16a. Dece	dent's Usual Occup	oation		16b. Kind of	Business/Inc	dustry			
21215-0036	thin 72 ie. ian "n.	Completed	(Specify only highest Elementary/Secondary (0-12)	1) (1-4or 5+)	life. I	DO NOT use retire	1	king		T. (
2	led wi tygien her th		12			Lega	1 Secreta		ne (First, Middle, N		Firm				
anc	\$ 0 m @	Be	17. Father's Name (First, Middle, L John Sulliva					1	Durning	iaideri Surria	une)				
Maryland	es 1 and 2 should be filed within 72 hours after death with the Marylan of Heatih and Mental Hygiene. of Heatih and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show a cother traumatic event, it is Medical Examiner must be notified at a cother traumatic event, it is Medical Examiner.	7	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	City or Tow	n, State, Zip	Code)			
Σ	and 2 salth a n 27 is er tra		Jeffrey B. Rober	cts/Son				oad, Gait							
altimore,	ges 1 If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal from	n State	20b. Place of Dispo cemetery, crer A11 Sou1	sition (Name of natory or other pla	^{ce)} Nove	mber	20c. Location	,				
ᆵ	permit. Pages 1 Department of I Important: If ite any Injury or ot		4 ☐ Donation 5 ☐ Other (Sp	ecify)		Comotory		: 6. /	009	German	ntown,	Maryland			
Ba	perm Depa Impo any I		21. Signature of Funeral Service	Licentere H		101498 R	ockville	, Inc. 30	O West M	ontgon	hery A	neral Home/ venue			
			23a. Part 1. Enter the disease, or o	complications that	caused the	d th. Do not ent	er the mode of dy	n, such as cardiac	or respirator arre	est,		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	23a. Part 1. Enter the disease, or complications that caused the duth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in such line. Immediate Cause (Final disease or condition a											
, ,	/Medical Examiner		resulting in death)	Due to	o (or as a co	nsequence of):									
		ě	Sequentially list conditions, cause. Enter Underlying	b. — Dua to	(or as a co	nsaquenca of):									
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2,	cate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a co	nsequence of):									
8760,	ficate be executed physician and s the burial-transit	dical		d											
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က်	ires th signed	þ	Part II. Other significant condition	ns contributing to	death but no	of resulting in the u	nderlying cause giv	ven in Part I.		s 2 No		he cause of death?			
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Vital	sician: The k certificate ha irector, page 2	a	25. Was case referred to medical				G/A	26. Place of Dea	1 ☐ Yes 2 th (Check only on		1 □ Yes	2 LINO			
<u></u>	hysic this ce	To B	examiner? 1 ☐ Yes 2 ☑ No			2 ER/Outpatier	it 3 🗆 DOA		ome 5 Reside	ence 6 □C	ther (Specia	(y)			
Division of	Jing P. After I	ion:	27. Manne Death 1 datural 5 ☐ Pending	(Mo	e of Injury onth, Day, Ye	ear) 28b. Time o	Wor	ryat rk?]Yes 2 ⊟No	28d. Describe ho	w injury occi	urred				
<u>ISI</u>	Attendent death	fical	2 Accident investig. 3 Suicide 6 Could n		e of Injury	At home, farm, str Specify)		1103 2 110	28f. Location (St		mber or Rura	al Route Number,			
\leq	s after	Certification:	4 ☐ Homicide determine	buil.	ding, etc. (S	ipecity)			City or Town	, State)					
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director, t		(Check only 2 Medical 8	Examiner: On the	basis of exa	amination and/or in		ime, date and place opinion, death occu							
	o the inthin 2 or the long the long the long length of the long length l	Medical	29b. Signature and title of certifier	and ma	inner stated		29c. Licens	se number	2	9 g . Date sigr	ned, (Month,	Day, Year)			
	⊢≯⊨ŏ		1 Vanle	e (1).	Ko	reshir	1	2172	6 7	loren	rper	4.2009			
	α		30. Name and address of person v	vho completed car	use of death	(Item 23a) (Type,	Print)	011/0	20072	UVU	V 4 V	10001			
	\		Charles Karesh	26033	Ridge	Road, D	amascus,	Maryland	20872						
	Sta Registr		31. Date filed (Month, Day, Year)	19 Sanu	negistrars	Signature									
						- //									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:07 AM Novembe mono Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospice nter WSON If Under 1 Year If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 213-26-8756 Months Days Country) **Director** Mary Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 👿 No MD Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral akleigh nited Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: White 3 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. of Juvenile College (1-4 or 5+) Elementary/Seconday (0-12) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Schmal Kaymond F. Schm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funeral Chapel 1

Burial 2

Cremation 3

Removal from State Nov 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) m.D torest Itill 22. Name and Address of Facility
Livans Funeral Chapel & Cremation Services
8800 Harford Road Parkville MD 21234 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Henorhan disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury pue to for as a consequence on. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) HOSOICE 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R149194 November 5,2009 15x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21204 Touson, Grant Chas 6201 11. sus 2. Registrar's Sign 31. Date filed (Month, Day, Year) 2009

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per Fh 8897 11/6/09 TT

State of Matyland / Department of Health and Mental Hygiene
Amend #8 per Fh 8897 11/12/09 Cartificate of Death Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2009 Nov. 5:40A M /Medical cility Name (If not institution, give 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Future Care-Homewood Birthplace (State or Foreign County) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 100M 2□F 80 214-24-5592 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 811 Homestead St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Pyes 2 No If Yes, Give Korea Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72 Department of Heelth and Mental Hygiene important: if item 27 is marked other then "na any Injury or other treumstic event, the Medic one. Elementary/Secondary (0-12) College (1-4or 5+) Unk Unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cataldo Sorrentino Tella Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 Wycliffe Ave. Parkville, MD 21234 Jolene Baldwin/Friend 20b. Place of Disposition (Name of cemetary, crematory or other place) Nov. 11, 20a. Method of Disposition
1. □Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Baltimore, MD 2009 4 □ Donation 5 □ Other (Specify) Mol 585 22. Name and Address of Fac@AFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee Rebecco 3717 Green Pastures Dr. Balto. MD 21286 _Hackens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KELTAL Um klowy CANCES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ete hes been signed by the e page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? this certificate 2 No 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours effect death. To the Funerel Director: After Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/09 DO059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3612 Falls P4 Salys B=14 MD 21211 Valicet 70 31. Date filed (Month, Day, Year) 32 Registrar's Signature State ando Registrar

ovember os,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 35748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Arthur Sass, Jr. 2009 P_{M} November 6 - 55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, July 21, 9. Birthplace (State or Foreign Country) IOWA 7. Age (In vrs. last birthday) Funeral Min Hours 1 🔀 M 2 🗆 F Director 483-18-7763 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at any hijury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Monkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16720 York Road, P.O. Box 187 21111 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 🗌 Widowed 4 🗎 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FBT 12 Special Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank A. Sass, Sr. Vera Wunderlich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Sass/ Wife 16720 York Rd., P.O. Box 187, Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Immeritie Premajory or other place)
Church Cemetery-Glence 1 X Burial 2 Cremation 3 Removal from State 11/07/09 Glencoe, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
16924 York Road, Monkton, MD 21111 21. Signature of Funeral Service Licensee Flart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sudden Cardiac Physician/ sease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examir physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an this certificate has autopsy performed? Yes 2 X No prior to completion of cause of death? page 2 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 Residence 6 🛭 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 24 hours after death. work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury n 24 hours after death.

• Funeral Director: Af pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

2+1

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Man

06

Grant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

H. Charles,

32. Registrar' Signature

29c. License number

Towson,

K149194

MD

21204

29d. Date signed (Month, Day, Year)

November 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 03^{ay} 2009^{ear} **Janet** Scheler 2:53 p м Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country aryland 1 □ M 2 X F Months Days Hours Min. (Month, Day Year Director 77 214-30-3510 -22-1932 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Completed by Funeral Director 1 Tes 2 X No Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Acton 21234 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be flied within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify If Yes Give White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Data Processer Paint-Glass Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Darmody Teresa Malonev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Scheler-Daughter Acton Rd. Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 11-06-2009 Baltimore Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Funeral Home 21214 Leonard J. 5305 Harford Rd. Baltimore Md. 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition COLON CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease 1877) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) ျာ 1 ☐ Yes 2 🗶 No Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 28d. Describe how injury occurred 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

within 24 hours a To the Funeral Completed filled

NOVEMBER

SCHELER

Medical

29a. Certifier (Check

29b. Signature and title o

JACKIE

31. Date filed (Month, Day, Year)

JONES

CRNP

State

Registrar

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

City or Town, State)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

35750

			For State Registrar		,		tificate of I	Death	, ,	Reg. No.		
	Б	,	Decedent's Name (First, Middle,	Last)					2. Date of Dear	th		3. Time of Death
	Physicia Medic		James	L.		Sea	У		Novembe	$r 5^{y}, 20$	00'9"	8:35 A M
	Examin		4a. Facility Name (if not institution,					r Location of Death		4c. County		
			Gilchrist Hospic 5. Social Security Number			4 6 5 46 . ()	Tows		Lo D to CB: 41		ltimo	
	Funeral Director		219–28–1115 Usual Residence of Decedent	1 □X M 2 □ F	77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 2	^{Year)} 9,1932	9. Birthp Count Mary	place (State or Foreign try) Land
	ind show at	5	10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	/anyla 8a-f tified	Director	Maryland Balti	more		D	undalk					1 ☐ Yes 2 🛣No
	with the N 23a or 2 ist be no	Funeral Di	10e. Street and Number 8202 N. Boundary	Road			10f. Zip Code 21.2	222		10g. Citizen of USA		ntry?
	eath y	Ē	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Vas Decedent of ⊢	lispanic Origin? (Spe	ecify Yes or No-		e - Americ	
9800	ırs after d ural", or i il Examin	ρ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 If Yes, Give Year or Dates.	No		Yes 2 X No	an, Mexican, Puerto Specify:	Hicari, etc.)		ck, White, 6	
21215-0036	iin 72 hoi ie. han "nat e Medica	Completed	15. Decedent (Specify only highes: Elementary/Seconday (0-12)		+)	(Give I life. D	O NOT use retired)	during most of work		16b. Kind of B		
12	d with lygien ther th	Be C	12 years			Medi	cal Admin	nistrator		Bethleh		
Maryland	ld be file Mental H arked of atic ever	To B	17. Father's Name (First, Middle, La Leslie Seay	st)				18. Mother's Nam Georgia			e)	
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Rose M. Seay	o (Type, Print) Wife			-	and Number or Rura dary Road		-		^{200e)}
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Sp		cei	metery, cren	sition (Name of natory or other pla Cemetery			20c. Location Dundalk		
Balt	permit. Departimport Import any inj		21 Signature of Füheral Service Lic	enee onne	lli	1 22 7	Name and Addre	ss of Facility Funeral Ho ers Point	ome of D Road, D	undalk, undalk,	P.A. Md. 2	21222
			23a. Part 1. Enter the disease or c shock, or heart failure Ust on	omplications that caused	the deat	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
me. F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		stati	c Su	rcoma					Onset and Death
4	Examiner			,	conseque	31100 01).						
	ted f insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a	conseque	ence of):						
	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	C Due to (or as a	a conseque	ence of):						
8760	physics the l	Medical		d								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnan Other (specify)	су			ate of delive	ery Day Year
P.O.	that the		Part II. Other significant condition	s contributing to death b	ut not resul	lting in the u	nderlying cause gi	ven in Part i.	23e. Did tol	bacco use cont	ribute to th	ne cause of death?
S,	uires n sign	ed k	Sluce not	c Stenosi's					1 □ Y	es 2 🗆 No	3 🗆 Prot	oably 4 🕅 Unknown
of Vital Records,	ne law req e has bee age 2 sho	Completed by							24a. Was a autops perfor	sy med?	prior to cor death?	osy findings available mpletion of cause of
alF	an: Ti tifical tor, p	BeC	25. Was case referred to medical				26. P	lace of Death (Checi		2 IA NO	1 🗌 Yes	2 <u> 1</u> 10
Vit	nysici lis ce direc	To E	examiner? 1 ☐ Yes 2 🏋 No	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 🗆 DOA Oth	er: 4 Nursing Ho	ome 5 Reside	ence 6 🛣 Oth	er (Specify)	Hospice
on of	ending Plath.	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	tion	ry (Year)	28b. Time of injury	wor		28d. Describe ho	ow injury occurr	red	V
Division	al or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			ne, farm, stre	eet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	ne Hospil In 24 hour ne Funera pleted fills	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of extended the participant of the large practioner: To the	kamination	and/or invest	tigation, in my opini	on, death occurred a	t the time, date an	d place, and du	e to the cau	use(s) and manner stated.
	Vith Vith Con		29b. Signature and title of certifier	Jul CRNP			29c. Licens	e number 9 19 4		9d. Date signe		
	121		30. Name and address of person w					Towson	MD	21201	-1	
*	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 6 2	32 Registra		re	Mal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thelma Eleanora Scripture 2009 4:51 Medical November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5211 Daybrook Circle 328 Baltimore Apt Rosedale 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Months Hours Min. Director 508-16-9746 87 Colorado Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale Maryland 1 🗆 Yes 2 🔯 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5211 Daybrook Circle Apt 328 21237 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Etementary/Seconday (0-12) College (1-4 or 5+) 12 years Domestic Engineer Own Home years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o Roy Hageman Ruth Edi Beat other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Janice Von Restorff Daughter 701 Grantwood Road, Middle River, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o to November 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Bel Air , MAryland BelAir Memorial Grdns 4 ☐ Donation 5 ☐ Other (Specify) 7, 2009 Signature of Funeral Service Licensee c. Name and Address of Facility Innelly Funeral Home of 7110 Sollers Point Road, 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death Immediate Cause (Final varian Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-t Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death the P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No _ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ပ 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Funeral Director: After a steed filled in by the funeral 1 Natural 5 Pending 2 🗌 No 1 🗌 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month. Dav. Year) D68106

Registrar

DHMH 17 Rev 7/2009

State

DV

670/ N. Charle

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** SEWARD HELEN PARROTT 2009 November 4. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore KESWICK MULTI-CARE CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 27, 1 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔽 F 1914 95 216-20-9933 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be routified an once. 1X Yes 2 □ No Director Baltimore City Maryland 10g. Citizen of What Country? 10e. Street and Number **USA** 21211 700 W. 40th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allin Cary Seward, Sr. Helen Parrott ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 boulevard de Sebatopol, Paris, France 75003 Allin C. Seward, III 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Green Mount Crematory 11/11/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21. Signature of Fyneral Service Hensee

Martin D. Lawson 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ATHEROSCLUSTIC cordiovolor disease or condition resulting in death) ست ۸ /Medical Due to (or as a consequence of): **Examiner** Kid hearing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy in the past 12 more Month Dav Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed should should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has page 2 s autopsy performed? 1 Yes 2 No his certificate h I director, page spital or Attending Physician: Theours after death.
neral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I To the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 11/5/09. D0059056

State Registrar

9istrar NOV 0 6 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who come

Daljeet Saluja, MD,

32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

3612 Falls Road, Baltimore, Maryland 21211

Caroline Caroline Home for Hospice Denton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM - 0 X Yrs. 220 07 8796 89 **Director** 02/23/1920 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinant to notified at once. Director Caroline Greensboro Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 26075 Fox Grape Road 21639 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: ş 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) Sanitation Truck Driver Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Shanahan Margaret Reese ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarence Walls 3127 Keswick Road Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/04/2009 | Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disea: o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I only one cause on each line. Baltimore, Maryland 21225 Immediate Cause (Final PROSTATE **Physician** CANCER WITH METATASIS TO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ PATHORSSCUMOTIC CAMDIOVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 **2 €**√0 Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 12 Natural 5 Pending To the Hospital or Augustin 24 hours after death.
To the Funeral Director: Af 1 ☐Yes 2 ☐No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8897 11/6/09 TT
State of Maryland Department of Health and Mental Hygiene

1- State Amend #6 per FH g897 11/12/09 TT
Certificate of Death

Reg. No. 2 11/12/09

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

Shanahan

4a. Facility Name (If not institution, give street and number)

determined

DAFFIN

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

29a, Certifier

Medical

Philip

Physician

Examiner

/Medical

Reg. No. 2 1 9

2009

4c. County of Death

6:40 P M

10d Inside City Limits

1 □Yes 257 No

Marvland

White

Day

29d. Date signed (Month, Day, Year)

11/2/2009

Year

Day 31

2. Date of Death

October 0

State Registrar

DHMH 17 Rev 1/2001

parke

DENTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Lacey, MD

32. Registrat's Signature

LN

🗲 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO05 750 9

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1, 2009 Month **Physician** 22:29 November Patricia C. Siemien /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year Davs Hours Months 1 □ M 2 🖺 F 84 January 10, 1925 Wisconsin 398-16-7673 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with United States 20854 11121 Stackhouse Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: ģ White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 3 Should be filed within 72 th and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Special Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose McPhillips William Leo Coyle ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Michael Jon Siemien/Son 16909 Olde Mill Run, Derwood, Maryland 20855 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 5 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee, Repert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the to for as a numerouence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☒No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 21 No 1 🗆 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature an of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Atul Rohatgi, 32. Registrar's Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

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SIEMIEN, PATRICIAC.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Mayember 1, 2009 James Edward Stanton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5. Social Security Number roint are System Health 1779 If Under 1 Year | Munder 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑**M 2□ F Virginia Director 1944 230-58-4885 Sept. 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Medical Examiner a ust be notified at 1 ☐ Yes 2 XNo Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a 73 N. Main Street 21904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give and Mental Hygiene. Is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No <u>8</u> 3 Widowed 4 Divorced Year or Dates Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Wilbert Frank Stanton Jenny Lee Burdett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 Is any Injury or other trau Duane Stanton / Son P.O. Box 397, Woodbury, NJ 08096 altimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 11-4-09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility.
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Adenocarcinoma **MKNANN** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of): physician the burial Physician/Medical signed by the attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed IGHE 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 24 hours af Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Known TO AMSICIAN STANTON LAMES

tealth Care System 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 35756 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 7:30 PMM November Donald Lee Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day Ye Tune 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 1936 Min Months Days Hours 1 X M 2 □ F Virginia 73 579-46-7061 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "sedical Evan" in a tive to mother or Director 1 □Yes 2√ No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 147 Patuxent Mobile Estates 20711 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ሺNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐Yes 2X No Specify: <u>გ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 0 AC/heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Chester T. Smith Virginia Elizabeth Lyons ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trudy Smith/spouse 147 Patuxent Mobile Estates Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Sign ur Funeral Service Licer 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Pat 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate use (Final disease or condition resulting in death)

a.

This to (area a consequence of the condition of the conditio Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph d for use as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown þ signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an autopsy performed? 1 □ Yes 2 🔼No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending investigation in 24 hours area in 24 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Weier Bech, My 46052 11/3/09

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NUV U 6 ZUUS

parked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sound Bell, the 2001 Medical Parkway, annapolis, Mp

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JOHN** SILVERS NOVEMBER 2009 4:12A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death BALTIMORE **Examiner** 4b. City, Town, or Location of Death GILCHRIST HOSPICE CARE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 491-14-7758 1 💢 M 2 🗆 F Months Days Hours Min. Country) 04/2271920 Director 89 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7927 WINTERSET AVENUE 21208 USA filed within 72 hours after death with 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: WHITF Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWNER SELF EMPLOYED SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked o any injury or other traumatic even MANUS SILVERBERG LEAH ZEMEL 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4106 WESTVIEW ROAD BALTIMORE, MD 21218 BRUCE SILVERS / SON Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PARK 11/05/2009 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signar re di Funeral Şervice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Month Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag-1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and addre

CHARLES 31. Date filed (Month, Day, Year)
NOV 0 6 2009 32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

NOEWOT

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 200 **Physician** orraine man ovember /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner izabeth Himore a Cent Birthplace (State or Foreign Country)
 M 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 218-03-4683 90 01-31-1919 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, he Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3320 BENSON AVENUE 21227 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ş Specify. 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL CLOTHING OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH ဥ HYMAN **TITELMAN** MOGOI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MYRA PEREL/DAUGHTER 5108 FRANKLINTOWN ROAD, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11-05-2009 BALTIMORE. MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS. of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears oronari disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ears 5-6 10515 squer tially list or cities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ears nrom led by the attending physician and detached for use as the burial-trar burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ensim IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknow signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 A No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the I within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 200 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) Genson mo 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35759 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 4, 2009 **Physician** 8:00 A.M Siwak James John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Canton Harbor Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Days 91 218-09-3288 Oct14,1918 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Md. Baltimore Dundalk 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1511 Rita Road 21222 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygier fitem 27 is marked other the r other traumatic event, In-8th Machinist Greif Brothers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Siwak John Anna Holewinski ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any injury or other trau Marcianna Kowalczik/Daught 2400 Grable Court Forest Hill, Md.21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition November 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Bayview Crematory 5, 2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Tolant 200 1201 Dundalk Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hypertension **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) bed by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2X ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral D 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tite of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 62194 November 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chintan Desai, M.D. 301 St. Paul Place, POB 519, Baltimore, Md. 21202

State Registrar 31. Date filed (Month, Day,

			1 - State of Ma	ryland / Depa	artment of H	ealth and	Mental Hy	giene Reg. 200	9 35760
	Physici		1. Decedent's Name (First, Middle, Last) Frank Truett		timodic of L	Jean	2. Date of Dea Month	ath	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number) Genesis Cromwell, 8710 E		4b. City, Town, or Baltim		ath	4c. County of Balts	Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age 238−26−3630 1⊠M 2□F 85	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mir	n. (Month, Da	30,1924	B. Birthplace (State or Foreign Country) South Carolina
	Maryland a-f show illied at	ctor	MD Baltimore	10c. City, Town or Lo	ocation	Dunc	dalk		10d. Inside City Limits 1 ☐ Yes 2€5xNo
	3a or 28	Il Director	10e. Street and Number 1956 Ewald Ave.		10f. Zip Code 212	2.2		10g. Citizen of Wh	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marcial Examinating trivial be naffied at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 12. Was Decedent E Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Black,	American Indian, White, etc. White
Maryland 21215-0036	I within 72 ho iiene. r than "natur the Modical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years	(Give	dent's Usual Occupa kind of work done of DO NOT use retired th Master	furing most of w	rorking	16b. Kind of Busi	ness/Industry Industry
/land ?	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) William Wilson Truett	WOI	5.11.11.00.00	18. Mother's N	ame (First, Middle, Sallie		
	and 2 sho ealth and I n 27 Is mu		19a. Informant's Name/Relationship (Type, Print) Mrs. Sallie Bolling (Daugh		ng Address <i>(Street a</i> 56 Ewa1d		Rural Route Numbe undalk, M		
Baltimore,	Pages 1 a nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		matory or other plac	·	Date 1/5/2009	20c. Location · C	ity or Town, State River, MD
Balti	permit. Page Department of Important: If any injury or once.		21. Signature / Fineral Service Licensee	22	2. Name and Addres Duda-Ruck 7922 Wise	ss of Facility	1 Home of	Dunda1k	. Inc.
	Physician and Medical Examiner	Examiner	Sequentially list conditions, if any, leading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events	the death. Do not entle.		g, such as cardi			Approximate Interval Between Onset and Death Minutes days years
.O. Box 68760,		by Physician/Medical	d	2 Fetal death 3	□Ectopic pregnancy			23d. Date Monti	
rds, P.	quires that in signed E uld be deta		Part II. Other significant conditions contributing to death but Dement:	t not resulting in the u	inderlying cause give	en in Part I.			ute to the cause of death?
Records,	: The law require cate has been signage 2 should b	Completed	Bladder eancer					rmed? pri	ere autopsy findings available or to completion of cause of ath? ☑ Yes 2 ☑ No
Division of Vital	ding Physician n. After this certific funeral director	To Be	25. Was case referred to medical examiner? 1 Yes No	nt 2 ER/Outpatier y 28b. Time o Injury	of 28c. Injury Work	er: Nursing	eath (Check only of Home 5 Thesic 28d. Describe h		
Divis	tal or Attano s after death al Director: ed in by the	Certification:	4 Homicide building, etc.	ry - At home, farm, sti . (Specify)	reet, factory, office	20.00	28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or in	ivestigation, in my o	pinion, death oc	curred at the time,	date and place, an	d due to the cause(s)
)	To To Com	2	29b. Signature and title of certifier Barbara J. McCles	Ley, CRN	29c. Licenson			29d. Date signed (
	141		30. Name and address of person who completed cause of de Barbara J. McCleskey	ath (Item 23a) (Type,	Print) 710 Em	ge Rd	, Baltin	ane, MD	21234
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registra NOV 0 6 2009 Seneth	A. Aas	led	9		<u> </u>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Trenner November Edward J. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Nursing Center Towson 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours (Month, Day 1 XM 2 1 Director 82 214-22-5301 Sept. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 Funeral 7917 Gray Haven Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 XWidowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Steelworker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth E. Carolan Albert W. Trenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 200 Hitching Post Drive Bel Air, MD $_{2101}$ Mary A. Weisgerber (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 11/6/2009 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23 art 1. Enter the disease, or cour leations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of one cause on each line. Immediate Cause (Final disease or condition Physician/ Myocardia Medical resulting in death) Due to (r as a consequence of) Examiner Securatially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Shestosi 24a. Was an autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Hospital or Attending 1 Natural 2 Accident 3 Suicide work? 1 Yes 2 No injury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 58303 November 3 Clarks ST TOUSEN MO

Month

11:08 AM

Baltimore Co.

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Year

1 Yes 2 XNo

9. Birthplace (State or Foreign

Maryland

White

2009

Black, White, etc.

12+1

Registrar

31. Date filed (Month, Day, Year) 06

29a, Certifier

(Check only one)

29b. Signature and title of certifie



0

person who completed cause of death (Item 23a) (Type, Print)

7011

			1 - For State State Registrar	of Maryland		artment of F rtificate of		, ,	jiene leg. No. 2 N	00	05760
İ	Physic /Medi		1. Decedent's Name (First, Middle, Last) EDWARD	DEWIT			BOR	2. Date of Dea Month	th Day	Year 2009	3. Time of Death 21: 19 M
Market State of the State of th	Exami		4a. Facility Name (If not institution, give street and n Howard County General	umber)			r Location of Deal	th	4c. County		
	Funeral Director		5. Social Security Number 233-09-8972 Usual Residence of Decedent 6. Sex 1 ▼ M 2 □ F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 7, 1917	Coun	ace <i>(State or Foreig</i> n try) g inia
	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Exv. ii er must be notified at	Director	10a. State 10b. County MD Howard	10c. City, To		ott City				10	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a or 2		10e. Street and Number	000		10f. Zip Code		1	0g. Citizen of V	/hat Count	try?
	ms 23	Funeral	3010 North Ridge Road C	-800 cedent Ever in U.S.	13.	Was Decedent of E		Specify Yes or No-	USA 14 Back	e - America	an Indian
5-0036	ours after or ral", or itel	b	Armed F 1 □ Never Married 2 □ Married 1 □ Yes 3 □ Widowed 4 □ Divorced Year or 1	orces? 2 □ No ive		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🙀 No	Specify:	to Rican, etc.)		k, White, e	
7	vithin 72 ho ane. I han "natul e Medieni	Completed	15. Decedent's Education (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo d)	rking	16b. Kind of Bu	siness/Ind	ustry
and 21	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examirer must be notified at	Be	17. Father's Name (First, Middle, Last) unk	I	3ake1	cy Chef	_	me (First, Middle, M		e)	
Maryland	nd 2 should alth and Mer 27 Is marke r traumatic	To	19a. Informant's Name/Relationship (Type. Print) Robert Yost Nephew	1	9b. Mailir 3770	ng Address (Street Loch Hig	unk ^{and Number or Ri} hland Pk	ural Route Number	; City or Town,	State, Zip	
more,	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1₺ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State		sition (Name of natory or other place	i		20c. Location -		
Baltimor	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	califer.	- Fu	Name and Address neral Hot 30 Edmon	ss of Facility St me of Ca	erling As tonsville	hton So	hwab	Witzke
	Physician		23a. Part 1. Enter the disease, o complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	caused the death. Deach line.	o not ent	er the mode of dyin	g, such as cardia	or respiratory arm	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to	or as a consequence	e of):						7 days
,00,	icate be executed physician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequenc							
. C. BOX 60	To use rospital or attending prystician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	tcome of pregnancy birth 2□Fetal dea nant at time of death nown		Ectopic pregnancy	1		23d. Date Mor	e of deliver	y Day Year
1 (SD)	quires that en signed l uld be det	by	Part II. Other significant conditions contributing to d Atrial from Ilation	eath but not resulting			en in Part I.	23e. Did tob 1 ☐ Ye			e cause of death?
יייייייייייייייייייייייייייייייייייייי	ang Pnystcian : The law re n. After this certificate has ber funeral director, page 2 sho	Completed						24a. Was ar autops perform 1 □ Yes 2	/ pi ned? do	/ere autop: rior to com eath? Yes 2	sy findings available pletion of cause of
	sician certifi rector,	Be	25. Was case referred to medical examiner?			l Oth-		th (Check only one			
5 2	Prnys er this eral dii	.T	1 Yes 2 No 1 Solution 1 No So		Outpatien Time of	t 3 ☐ DOA Othe	4 LI Nursing H	ome 5 ☐ Reside			
	Attending at death. ector: Afte by the fund	Certification:	1 Matural 5 Pending (Mon 2 Accident investigation	th, Day, Year) of Injury - At home, ing, etc. (Specify)	Injury	M 1 🗆	? [™] ∕es 2 □ No	28f. Location (Str	eet and Numbe		Route Number,
5	ospital or hours afte uneral Dir		29a. Certifier 15 Certifying Physician: To the	best of my knowled	ne. death	occurred at the tim	ne, date and place	City or Town,	auce(c) and mar	ner as sta	ited.
Tothoti	within 24 To the F complete	Medical	one) and man 29b. Signature and title of certifier	ner stated.		29c. License	number	29	d. Date signed	(Month, D	ay, Year)
			30. Name and address of person who completed caus	e of death (Item 23a) (Type, F	Print) D 0 Print) Patur	0625	60	NOV	03	2009
	Stat	te	MICHAEL DRUMMOND 31. Date filed Month, Day 2000000 32. R	LO 724 egistrar's Signature	Litt	le ratur	cent fo	rkway	COLUMB	210	441

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:48 AM Medical Examiner on, give street and number) Town, or Location of Death 4c. County of Death ownson 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign Year **Funeral** Month, Day Months Min Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Raltimore Mδ 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. nd Mental Hygiene. marked other than "natural", or ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle should be file hand Mental H ပ permit. Page 1 and 2 sho. Department of Health and Important; If item 27 is m any injury or other traum 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral mo 1553 complications that caused the death. Do not enter the mode of dying, 23a. Part 1. Enter the disease. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Carra disease or condition Medical resulting in death) **Examiner** weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last SQUAMOUS CELL Corunna attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 Dunknown Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 No Yes Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WAD (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 🖎 Natural 5 Pending injury work? 2 No Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat title of certifie 58 302 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Charles (W) CHAMPES 31. Date filed (Month, Day, Year) State 2009 Registrar

			1 - For Amend Items Registrar	s 23aPt1,25	laryland / per me	Departr 8897 Certifi	nent of H icate of L	lealth a 9dhb Death	and Me	ntal Hy	giene , Reg. No. '	2009	3	5764
	Physici	an	1. Decedent's Name (First, Middle,							Date of Dea		Year		ne of Death
-	/Media	cal	4a. Facility Name (If not institution,	Dolores		olson	0" T			ctobe	1			:10 PM
	Examir	ier	Arden Courts o		7	4D.	. City, Town, or Potoma		of Death			Dounty of Dea		
	Funeral			6. Sex 7. A	ge (In yrs. last I		Under 1 Year	If Under	24 Hrs. 8.	Date of Birt		Montgo 9. Bir	thplace (S	tate or Foreign
	Director		354-24-5573	1 □ M 2 🛛 F	78	Yrs. Mc	onths Days	Hours	Min.	Date of Birl (Month, Da Iay 22	, 193	1 Mic	higar	1
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locatio	on .						10d. Insi	de City Limits
	Maryl -f sho	tor	Maryland Monte	omery		ckvill								Yes 2 X No
	h the	irec	10e. Street and Number	,02 /	1.0		0f. Zip Code				10g. Citiz	en of What Co	ountry?	
	23a c	ral	11801 Magruder	Lane			2085	2			Uni	ted St	ates	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Everting must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces d 1 Tyes 2 M If Yes, Give Year or Dates:	Ever in U.S. ? No		Decedent of His s, specify Cubar √es 2 X No			y Yes or No an, etc.)		4. Race - Ame Black, Whit Specify:		an,
2-0	72 hou	Completed	15. Decedent's	Education	16	a. Decedent's	s Usual Occupa	ation			16b. Kin	d of Business	/Industry	
21	ithin 7 ne. nan "r	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO N	of work done d IOT use retired)	luring mosi)	t of working					
121	filed within Hygiene. wher than "		47. 5-4	3		Homem						n Home	:	
Maryland 21215-0036	ould be fi Mental H arked ot atic ever	m .	17. Father's Name (First, Middle, La William Mattre	·					er's Name <i>(F</i> rion			urname)		
aryi	should and Mer s marke umatic	우	19a. Informant's Name/Relationship		19	9b. Mailing Ag	idress (Street a					Town State	Zin Code)	
ž	1 and 2 Health a tem 27 is		Barbara L. Kirk	patrick/dau							-		. ,	52
ore	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 🏅 Cremation 3		20b. Place		n (Name of ry or other place		Novembe:			ation - City or		
Baltimore,	Pag tment tant: I		4 Donation 5 Dother (Spe	ecify)			matorium,		2009		Beth	esda,	Mary1	and
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fundal Service Lie	MI	M0130	0 /55/	me and Addres t A. Pum Wisconsin	n Aven	ue, Bet	hesda,	Maryl.	sda-Chev and 2081	y Chas 4-3501	e, Inc.
			23a. Part 1 Inter the disease, or conshock, or heart failure. List or	omplications that cause nly one cause on each I	d the death. Do ine.	o not enter the	e mode of dying	g, such as	cardiac or re	espiratory ar	rest,		Approx Interva	rimate Il Between and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	conic Bo		struct	ion					4 we	
	Examiner				a consequence		ia						2 ye	070
		Jer	Sequentially list conditions, if any, leading to immediate	D	a consequence					11	1/		2 ye	als
37.	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	cAbc	lominal	Surge	ry	\mathcal{O}	. /	///	EVAMINE	R	8 Ye	ars
8760,	ficate be executed physician and s the burial-transit	Ĕ	resulting in death) Last	Due to (or as	a consequence	e of);		1	DAL PROVE	D'BY MEDICA	LUV			
387	icate I physic the b	dical		d	-		d	ERTIFICAT	Brain					
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after decet. Within 24 hours after decet. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 Fetal deal at time of death		opic pregnancy er (specify)					d. Date of de Month	livery Day	Year
σ.	that the part of t		Part II. Other significant condition	s contributing to death t	out not resulting	in the underly	ying cause give	n in Part I.		23e. Did to	bacco use	e contribute to	the cause	of death?
Division of Vital Records,	quires an sign uld be	sq pa	Alzheimers Di	sease						1 □ Y	es 2 📉	No 3□P	robably 4	1 ☐ Unknown
ဝ၁	aw re as bea 2 sho	Completed								24a. Was a		24b. Were at	topsy findi	ings available
Œ Œ	ding Physician: The h After this certificate h funeral director, page	Som								autop perfor 1 ∐Yes		prior to death? 1 □ Yes		of cause of
Vita	cian: certific ector,	Be (25. Was case referred to medical examiner?	11		*			of Death (C					
of	Phys this c	2	1 X Yes 2-10 No. 27. Manner of Death	Hospital: 1 Inpati	ent 2 ER/C	Outpatient 3		4 KM NU				□ Other (Spe	cify)	
on	ding th. : After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay, Year)	Injury	28c. Injury Work? 1 □ Y	es 2.⊟N		. Describe h	ow injury	occurrea		
Visi	Atter	itica	3 Suicide 6 Could not	be 280 Place of In	ury - At home, f					Location (S	treet and	Number or R	ural Route	Number,
	tal or rs afte al Din ed in	Certification: To	4 Hornicide	building, er	с. (Зреспу)					City or Tow	n, State)			
	he Hospi in 24 hou he Funer ipletely fill	Medical	29a. Certifier 1 X Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination a	ge, death occ and/or investig	urred at the tim gation, in my op	e, date an pinion, dea	nd place, and th occurred	I due to the at the time,	cause(s) a date and p	and manner a place, and due	s stated.	use(s)
	Vith Con	2	29b. Signature and title of certifier	IH C	21	1.	29c. License D2355					signed (Mont mber 2		
	On	-	20 Name and address of	w 11 d		N CTS = S					MOVE.	miner 7	, 200	
	20		30. Name and address of person when Robert H. Blee,		eath (Item 23a) Wiscor	, , , , , ,		1400 -	Chev	v Chas	e. M	D 208	15	
	Stat		31. Date filed (Month, Day, Year)		ar's Signature			,	311C V	, 511412	-,		-	
	Registra	ar	NOV 0 6	ZUUS Dens	un B	4960	Page 1							

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland	-	artment of F rtificate of		-	giene Reg. No?	25765
İ	Physici		1. Decedent's Name (First, Middle, L	ast) FARLAN	W	ALKE	in_		2. Date of De Month		3. Time of Death
and and	/Medic Examir		4a. Facility Name (If not institution, g. BATIMOLE LEHASI	ive street and number)		CARE		r Location of Dea		4c. County of Death	1
	Funeral Director		261-68-9212	Sex 1X M 2 ☐ F	e (In yrs. k	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) Co.	nplace (State or Foreign untry) New York
	Maryland F show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltime	ore		, Town or Lo				-	10d. Inside City Limits 1 □ Yes 2 🎖 No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 24 Shore Rd.				10f. Zip Code 2121	9		10g. Citizen of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Markel Examinator must be notified at once.	by Funeral I	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If If Yes, Give Year or Dates:	No		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 🛂 No	dispanic Origin? (an, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	0	
21215-0036	thin 72 hour e. an "natural	Completed I	15. Decedent's E (Specify only highest go	Education		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)		16b. Kind of Business/l	ndustry
and 21	ould be filed wil Mental Hygien arked other th atic event, the	Be	17. Father's Name (First, Middle, Las	t)		Indep	endent C			Transporta	tion
Maryland	id 2 should Ith and Mer 27 is marke 1 traumatic	2	Berrisford Har 19a Informant's Name/Relationship Toni K. Walker		<u>-</u>		ng Address (Street		aural Route Numbe	Kinsella er, City or Town, State, Z vland 2121	
altimore,	Pages 1 and nent of Health int; If item 27 iry or other to	3	20a. Method of Disposition 1 Burial 2 Cremation 3 Donation 5 Other (Spec	☐ Removal from State		ace of Dispo metery, crer	sition (Name of natory or other place	ce)	Date	20c. Location - City or Towson, Ma	Town, State
Balti	permit. Pag Department Important: I any Injury o once.		21. Sign ture of Funeral Service Lice	-	20		2. Name and Addre	ss of Facility Du	da-Ruck	Funeral Homo MD 21222 D	e of
	Physician	0 0	23a. Part + Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lir	ne.		er the mode of dyin		c or respiratory a		Approximate Interval Between Onset and Death
	/Medical Examiner	er	resulting in death) Sequentially list conditions,	b. Due to (or as	IAL	Po	LYPOS	15			
oʻ	icate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as							
k 68760		Medical	IF FEMALE:	▲ d							
O. Box	at the death certifi by the attending t tached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other <i>(sp</i> ec <i>ify)</i> _	у		23d. Date of deli Month	very Day Year
rds, P.	es the igned	þ	Part II. Other significant conditions	contributing to death b		ting in the ur	nderlying cause giv	en in Part I.		obacco use contribute to Yes 2 ☐ No 3 ☐ Pr	
	The law ate has t page 2 si	Completed							24a. Was autop perfo 1 □ Yes	osy prior to o rmed? death?	topsy findings available ompletion of cause of
VITal		Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only o	nne)	
0	g Physer this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ry :	28b. Time of	it 3 DOA	4 🖼 Nursing I		dence 6 Other (Spec	eify)
UIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: To	1 Natural 5 Pending investigation 3 Suicide 6 Could not to determined	De Diago of Inju		Injury ne, farm, stro	M 1 🗆	k? Yes 2 □No	28f. Location (8	Street and Number or Ru vn, State)	ral Route Number,
_	Hospital 24 hours a Euneral C	Medical Ce	29a. Certifier 1	hysician: To the best ominer: On the basis of and manner sta	f examinati	ledge, death on and/or in	n occurred at the tivestigation, in my c	me, date and plac opinion, death occ	ee, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (Month	
			1 Lew	ulen	and	_	DE	30272	-	NOVEMBER O	4,2009
	let1		30. Name and address of person who	completed cause of d	eath (Item)	23a) (Type, I	Print) Y NAVEN	BOULE	THEO B.	NOVEMBER O	MARKAND 2016
į	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 6 200	32. Registra	ar's Signatu	are from					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CTOBER Maxine Anderson Wilson Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death APINE MASHINGTON MEDICA PAKTIMORE CIEN BNITE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Min 1 □ M 2 🛛 F 220-40-9919 66 02-22-1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2602 Clarion Court #304 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Specialist Government Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert C. Anderson Mildred Elizabeth Walter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremy Wilson / Son 848 Oyster Bay Harbour Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 10-28-2009 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 eart 1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ns 23a or 28a-f show

ortant: if item 27 is marked other than "natural", or items injury or other traumatic event, the Modical Examinating in

Department of Health a Important: If item 27 is any injury or other trau

and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

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the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the buriat-transit burial-tran signed by t

E Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any leading to framediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown Part II. Other significant condition	b. C. METASTATIC C. Due to (or as a consequence of):	RE ALL BLADON	er Chn	CEZ.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ctopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
			24a. Was an autopsy performed;	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	Others	ath <i>(Check only one)</i> Home 5 ☐ Residence	6 Other (Conside)
27. Manper of Death 1 Natural 2 Accident 3 Suicide 6 Could no determin 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
3 Suicide 6 Could no determin		factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my knowledge, death oc kaminer: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and plac tigation, in my opinion, death occi	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	ni)	29c. License number	29d. [Date signed (Month, Day, Year)
30. Name and address of person w	ho completed cause of death (Item 23a) (Type, Prin	Inve gle	Burnie	ms 20161

State Registrar

31. Date filed (Month, Day

within 24 hours a completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Francis Woodard, III	State of Maryland / Department of Health and N	V

		1- For State Registrar		ertificate of			Reg. No.	200	9 3576
Physicia Medical Exami		1. Decedent's Name (First, Middle,	•			2. Date of Month	of Death Day Der 28, 2009	Year	1542 hrs
/ S		Francis Joseph 4a. Facility Name (if not institution,	qive street and number)	4	o. City, Town, or Location			ounty of Death	
		13200 Choptank Road			Chase		Bat	timore Coun	ty
Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs.	last birthday)			of Birth (MM/DD)/YYYY) 9. Birth	place (State or
Director		220 48 1590	1X M 2 F 62	Yrs.	Months Days Hour	s Min. Dec.	2,1946	Cour	Maryland
		Usual Residence of Decedent			· · · · · · · · · · · · · · · · · · ·				10d. Inside City Limits
w any		10a. State 10b. County		y, Town or Location	'n				1 Yes 2 X No
Maryland 28a-f show 1 at once.	tor	Maryland Baltin 10e. Street and Number	ore	Chase	10f. Zip Code		I 10a Citizo	n of What Count	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Director	13200 Choptank R	D.C.		21220		,		y:
ith th		11. Marital Status	12. Was Decedent Ever in I	US 13 Was	Decedent of Hispanic Or	rigin? (Specify Yes		SA 4. Race - America	an Indian, Black,
eath w	Funeral	1 Never Married 2 Man		If Ye	s, specify Cuban, Mexica	n, Puerto Rican, et	c.)	White, etc.	
after d	by Fu	3 Widowed 4 X Divor	ced If Yes, Give Year	1	Yes 2 X No specif	y:	Sį	_{pecify:} Whit	e
iours a		15. Decedent's Education (Specif	y only highest grade completed)		s Usual Occupation (Give st of working life. DO NO		16b. Kin	d of Business/In	dustry
5-0036 led within 72 hours a Hygiene. t other than "natura the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nsultant	,			
21215-0036 und be filed within 7 Mental Hygiene. marked other than	om	17. Father's Name (First, Middle, L				er's Name (First, M		onstruct	TOU
215 e filed al Hy ced of	Be C	Francis Joseph W	,			elyn A.		,	
212 buld b I Men mark	To E	19a. Informant's Name/Relationshi		19b. Mailing	Address (Street and No			or Town, State,	Zip Code)
MD 12 sho 12 sho 127 is umati		Robyn A. Cutsail		401 St	ıgarberry Ct	. Edgewo	od, Mary	yland 21	040
re, land freal freal		20a. Method of Disposition 1 Burial 2 X Cremation	O Domested from Chain	crematory or oth	tion (Name of cemetery, er place)	Date		cation - City or T	
Pages nent o ant: 1 or oth		4 Donation 5 Other Spe		yview Cı	rematory Inc	11/6/20	09 Balt	timore,	Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		21/ Signature of Funeral Service L	icensee	22. N Bri	ame and Address of Facilizadzinski Fu	neral Hor	me P.A.		
	113	John W. Bu	omplications that caused the dear	1141	II UIO KASTE	rn Avenn	D HIGGOV	Maryla	nd 21221 Approximate Interval
Physician Medical		failure. List only one cause o	n each line.			real drace of respirat	ory arrest, shoo	K, OF HOUR	Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardic		ease				
		Sequentially list conditions,	b	,					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):					
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ecuted and transit			d						
a a a	Medical	UNPENDED	AMENDED						
760, ficate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		al dash 3 Ecto	nic pregnancy	1	Date of delivery Month D	ay Year
c 68 n certil ending use as	'sician/	past 12 months?	1 Live birth Pregnant at time of	death	al death 3Ecto ner (Specify)	pic pregnancy	, "	violiti D	ay rour
Box 687 he death certific	Physi	1 Yes 2 No 9 Unkr	g Unknown						
F.O. ires that the signed by t	by PI	Part II. Other significant condition	ons contributing to death but no	t resulting in the u	nderlying cause given in	Part I. 236			he cause of death?
S, P uires t n sign id be c									ably 4 Unknown
Records, The law require ficate has been si	Completed	<u></u>					autopsy	prior to c	opsy findings available on completion of cause of
Rec The la cate h	mo:					1 🗸	performed? Yes 2 No	death? 1 ✔ Ye	s 2 No
tal Rec cian: The certificate	BeC	25. Was case referred to medical examiner?				th (Check only one			
F Vit	101	1 ✔ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient				ce 6 Other	: Scene
Division of Vital tol or Attending Physician is after death. al Director: After this certiled in by the funeral director		27. Manner of Death 1 ✓ Natural 5 Pendi	28a. Date of Injury (Month, Day,Year)	28b. Time of I	njury 28c. Injury at Wo		scribe how injur	y occurred	
isio Atten r deat ector by the	icati	2 Accident Invest	igationAt	home, farm, stree	et, factory, office building,		ation (Street an	d Number or Ru	ral Route Number, City
Div pital or ours afte eral Dia filled in	Certification:	3 Suicide 6 Could 4 Homicide	not be				Γown, State)		
Trie los initials		29a. Certifier 1 Certifying Phy	ysician: To the best of my knowle	edge, death occur	red at the time, date and	place, and due to t	ne cause(s) and	manner as state	ed.
To the Howithin 24 h	Medical	one) 2 Medical Exam	niner: On the basis of examination and manner stated.	and/or investiga	ion, in my opinion, death	occurred at the tim	e, date and plac	e, and due to the	e cause(s)
E > E 8	Me	29b. Signature and title of certifier			29c. License numb	er	29d. D	ate signed (Moi	nth, Day, Year)
		N_ M	L,mn		O.C.M.E.		Octo	ber 29, 2009)
		30. Name and address of person v			Donn Chart Date	more MD 040	01		
10		Donna M. Vincenti, MD 31. Date filed (Month, Day Year)		K 1	Penn Street, Balti	more, IVID 212	· · · · · · · · · · · · · · · · · · ·		
- 3	tate trar	and he was	009 Registrar's Sign	19					

			1- State of Maryland 1tem State of Maryland 1990	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2009 357	68
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Frances J. Waylett	2. Date of Death Month Day Year 0ctober 24 2009 7:30	ath A M
27/20	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) Sunrise 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fo	reian
	Director		369-48-3437 1	Months Days Hours Min. (Month, Day, Year) Country) September 30, 1917 Canada	
	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Pedical Evaninar must be realthed.	ral Director	10e. Street and Number 41 W. McKinsey Road	rna Park 1	
21215-0036	72 hours after de 'natural', or items die Eraniner	eted by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Give	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: white edent's Usual Occupation e kind of work done during most of working	
nd 2121	e filed within al Hygiene. other than ' vent, the Me	Be Completed	17. Father's Name (First, Middle, Last)	ome Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname)	
Maryla	should and Mer s marke	10 E		Edith May Martin ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O Dividing Road, Severna Park, Maryland 2114	
Baltimore, Maryland	Heal Heal tem 2		20a. Method of Disposition 20b. Place of Disposition cemetery, cre		
Balti	permit. Pages Department of Important; If I any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1020 York Road, Towson, Maryland 21204	•
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate failure. Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat VEOVS	
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.		
O. Box	the death certific y the attending p iched for use as b	Physician/Med		□ Ectopic pregnancy 23d. Date of delivery Month Day Year	
ords, P.	The law requires that the date has been signed by the sage 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the careful significant conditions.	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 11Yes 2 No 3 Probably 4 Unkr	
	The la sate has page 2	e Completed	25. Was case referred to medical	24a. Was an autopsy performed? 1 □ Yes 2 No 26. Place of Death (Check onlone)	lable e of
f Vi	Physician: this certific ral director,	ro Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	Angiete	ed .
Division o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death Natural 5	of 28c. Injury at Work? M 1 Yes 2 No	
Div	pital or A ours after eral Direc filled in by		4 Homicide determined building, etc. (Specify)	treet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) ath occurred at the time, date and place, and due to the cause(s) and manner as stated.	
1	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	To the company of the	W	29b. Signature and lifte of certifier	29c. License number 29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>)	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Danny Lee, 1132 Annapolis	Rd, Odenton, MD 2113	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:25 PM WATSON NOVEMBER UDY 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPHINS BAYVIEW MEDICAL CENTER ALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Onth, Pay, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 218-80-153 Months Hours 1 □ M 2 💢 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Mudical Examiner must be nutified at 1 Yes 2 No Completed by Funeral Director more 10g. Citizen of What Country? 10e. Street and Number items 23a Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 ☐ Married ò 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life pDO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Meonee. College (1-4or 5+) Elementary/Secondary (0-12) Baltimore, Maryland Middle, Maiden Surname) 18. Father's Name (First, Middle, Last Be 2 State, Zip Code) 11334 19b. Mailing Address (Street and Number or Rural Route Number, City or Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Faneral Service Ligensee 23a, Part1. Enter the disease, or complications that caused the death. Do not en Approximate Interval Between Onset and Death mode of dving, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) BREAST **Physician** CANCER YEARS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit on the funeral director. Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 212 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide LC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Michael Saudo MEDICAL DOCTOR RES-000 NOVEMBER 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL SAUDER MD 4946 AVENUE EASTERN MD 21224 BALTIMORE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30, 2009 Month **Physician** 5:10 A^{M} Wenthold October Robert James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery 5614 Oakmont Avenue Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,) June 20, Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Social Security Number **Funeral** Months Days 1X M 2□ F Iowa 61 485-62-7063 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Directo Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 5614 Oakmont Avenue by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐Yes 2 X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Of Health Scientist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Gesing Alois Wenthold ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5614 Oakmont Avenue, Bethesda, Maryland 20817 Helen Christine Wenthold/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 4. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Bethesda, Maryland Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bet 7557 Wisconsin Avenue, Bethesda, Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) Renal Cell Carcinoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗓 No certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check onli one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

9707 Medical Center Drive, #300, Rockville, Maryland 20850 Manish Agrawal, M.D. 31. Date filed (Month, Day, Year)

29c. License number

D0062234

29d. Date signed (Month, Day, Year)

October 30, 2009

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C 1,2009 **Physician** Miao Yuan Yu November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 9403 Joppa Pond Road Parkville 8. Date of Birth May 23, 1937 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 72 068-80-0429 Director India Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Parkville 1 ☐ Yes 2 ☐ Xio Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 9403 Joppa Pond Road 21234 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deau Department of Health and Mental Hygiene. Important: If item 27 is marked other the any Injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: þ Specify: Asian 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Carpenter 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mei May Yap Soon Ling Yu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9403 Joppa Pond Road-Parkville, Maryland 21234 Cecilia Yu-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith 11/07/09 Rosedale, MD Certebry 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services h YVI torold 8800 Harford Road-Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vocartial disease or condition resulting in death) enterelion /Medical (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any learn's to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: signed by the attendir I be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records. 3 Probably 4 Unknown 1 ∏Yes 2 ∏ No Completed filled in by the funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: autopsy certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 **X**No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ise of death (Item 23a) (Type, Print) 1924 Gampbell Blood Fulfmore

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person

Suife 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh 2897 Half 6-09 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Vito Anthony Zappala 2009 November /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 7630 Tomlinson Avenue #17 Cabin John Montgomery 8. Date of Birth (Month, Day, Year) Jan. 1, 1946 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 63 Director 579-64-2037 Washington, D.C. Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐Yes 2 No Maryland Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -Tomlinson Avenue #17 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Exercitival ance. 20818 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: **Vietnam** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 X No <u>ک</u> 3 ☐ Widowed 4 ី Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Anthony Zappala 2 Ferne Teemlev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Zappala/Sister 2648 West Street, Falls Church, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2009 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, 21. Signature of Funeral Service Licenses Bethesda-Chevy Chase, Inc Maryland 20814 Whiten M01173 maple 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the buriaf-transit Due to (or as a consequence of) Physician/Medical attending phi for use as the IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) the □Yes 2□No 9 Unknown 9 I Unknown signed by t I be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Ischemic Cardiomyopathy 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate ha autopsy performed 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1X Yes 2 □ No Hospital: this Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check on one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Box 68760.₹

P.O.

Division of Vital Records,

State

Registrar

31. Date filed (Month, Day, Year)

Steven D. Lerner, M.D.

5530 Wisconsin Avenue #800, Chevy Chase, MD 32. Registrer's Signature

address of person who completed cause of death (Item 2.1 (Type, Print)

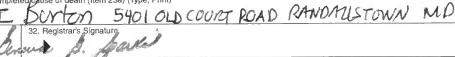
2009

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#100, perFH, 6897, 1176709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 8:05 A M **Physician** ZAVODYUK MARIYA 2009 Vovember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL 9. Birthplace (State or Foreign Country) KRAINE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 08/15/1926 Days Months 1 □ M 2 🗶 F 219-35-4081 83 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3615 FORDS LANE, USA 21215 #616 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Ye ar or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No WHITE Specify: Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "y any injury or other traumatic event, I'm Med gonee. Bookkeeping Elementary/Secondary (0-12) College (5-4or 5+) **BOOKKEEPER** BOOKEEP ING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **FEINSTEIN** NAUM ZAVODYUK BELLA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NAUM FEINSTEIN / SON 905 JOSHUA TREE COURT, OWINGS MILLS, MD 20b. Place of Disposition (Name of ARLINGTON CHIZUK 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/05/2209 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AMUNO 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Linens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician LYMPHOMA END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the ; g 🗆 Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Respiratory Failure due to Lymphoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed Right Main Stem Branchus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performe certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)
NOV 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1445931

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 23, 2009 Physician Beulah Naomi Ardinger A^{M} 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hagerstown Loyalton of Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 20, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🛛 F Months 88 214-16-1241 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be rutilled at once. Maryland Washington Co. 1 ☐ Yes 2 X No Hagerstown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21742 11922 Phylane Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: 3 Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victor O. Bartles Nellie R. Repp ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3916 Wistman Lane, Myersville, Maryland 21773 Jorja J. Kline / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Oct. 27,2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North, Hagerstown, MD 21742 Illow, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical attending ph for use as tl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. holedocolith 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2 DNO 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00054451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bolicard Smithing Mayland 1H-10 Binha 22411 Jetterson an 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar D. par DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2009 Patricia A. Aldana 5:10 P October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🛱 F Months Days Min July 3 . 1942 Hours 215-42-9014 Director Usual Residence of Decedent shov 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho Director 10d. Inside City Limits Maryland Harford 1 Yes 2X No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Trimble Road, Apt. B-4 21085 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give No No Maryland 21215-0036 1 Tes 2 No Specify: Completed Specify: White 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Communications 4 other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Francis Plunkett Angela Lillian Figinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Winesap Court, Joppatown, Maryland21085 Maria Angela Dugan/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. 10-30-09 Baltimore, Maryland Stanislaus 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. mulacl 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, 2 KNo Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform this certificate Yes 2 🗴 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X10 Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

trar's Signature

29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 12:30 AM 19 October Eugene J. Anderson, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Temple Hills Prince Georges 7216 Karen Anne Dr. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Months Days Hours 1 🙀 M 2 🗆 F Director 372-20-6910 84 6, Virginia J<u>an.</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Temple Hills Maryland Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 U.S.A 7216 Karen Anne Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Ye ar or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ▼ Married 1 ∐Yes 2 No Specify Specify: ð White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Logistics Analysis Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, If once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue James Eugene J. Anderson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Mary Jo Anderson (Wife)</u> 7216 Karen Anne Dr. Temple Hills, MD 20748 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2009 | Buchanan, Michigan Oak Ridge Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Fatt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/Medical Examiner Completed by

Physician /Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Pages 1 and 2 should be

Be

The law requires that the death certificate be executed physician and s the burial-trans attending ph signed by the a d be detached for within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s To the Hospital or Attending Physician: Medical Certification: To

disease or condition resulting in death)	a. Malinant N		skin			-
Sequentially list conditions,	b	,				
if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
resulting in death) Last	Due to (or as a conseq	uence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	il death 3 □ Ectopic p			23d. Date of delivery Month Da	
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying o	ause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?
				24a. Was an autopsy performed 1 □ Yes 2 🛣	i? death?	y findings available bletion of cause of ☑No
25. Was case referred to medical examiner?				eath (Check only one)		
1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5XXResidence	e 6 ☐Other (Specify)	
27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factor	, office	28f. Location (Street City or Town, St	t and Number or Rural F tate)	Route Number,
29a. Certifier 1	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and pla n, in my opinion, death oc	ce, and due to the caus curred at the time, date	e(s) and manner as star and place, and due to the	ted. ne cause(s)
29b. Signature and title of certifier		29	c. License number	29d.	Date signed (Month, Da	ıy, Year)
New	b.m	H	101-10105		10/19/20	19

State Registrar 31. Date filed (Month, Day,

Blal

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene 20 3577 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Taylor Scott Burgess, Jr. October 0 24, 2009 7:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home 7. Age (In yrs. last birthday) St. Mary's Charlotte Hall 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ₩ M 2 □ F 91 December 4,1917 West Virginia 233-24-9442 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland St. Mary's Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29449 Charlotte Hall Rd. 20622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 전 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Taylor Scott Burgess, Sr. Aida Krankshaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Burgess 20606 Adkins Rd., Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 10/26/2009 Charlotte Hall, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Brinsfield-Echols Funeral HOme 30195 Three Notch Rd., Charlottte Hall, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or toget failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ZHEIMER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, by the δ signed b

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination that the Indianal Bone. 9008.

Baltimore, Maryland 21215-0036

page 2 s within 24 hours after death.

To the Funeral Director. After thi completely filled in by the funeral of within 2 To the I

		ntributing to death but not res		cause given in Pa	ırt I.		se contribute to the cause	
ESSENTI	ALF	PYPERTENS	TON			24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion death? 1 □ Yes 2 □ No	
25. Was case referred to examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ I	Lout		Check only one) 5 ☐ Residence 6	Other (Specify)	
2 Accident	Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	28	d. Describe how injury		
3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Special	orne, farm, street, factory)	ry, office	28	f. Location (Street and City or Town, State)	Number or Rural Route I	Vumber,
		slcian: To the best of my kno ner: On the basis of examina and manner stated.						se(s)

State Registrar

RAO KODALI 29c. License number D67788

Home

29d. Date signed (Month, Day, Year) 10.26.2009

Charlotte Hall,MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA

Charlotte Hall Veterans

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Magdolna Bart Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country Hungary 1 M 2 X F Months Days Hours Min. 1272971996 220-43-6872 Yrs. Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married <u>8</u> If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify. Completed 3 X Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gizella Krausz Paul Goldstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Bart - Son 11710 Old Georgetown Rd. #1101. N. Bethesda. MD20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 10/25/2009 | Clarksburg. Maryland 21. Signature of Furieral Similar License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD0709 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician. ONGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and bunial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the k IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 🗌 Pending 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Box 68760 **大**なり、これ Division of Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: or Attending Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

ONTROSE 26 2009

ROCKUILLE MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 15 2009 1621 Myrtle Blake Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Anne Arundel Medical Annapolis Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 🗓 F Hours Min. Jan 1 2 Year 928 Maryland 81 213-22-1848 **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a oi ury or other traumatic event, the Medical Examiner must be. Funeral 21403 USA 940 Bay Forest Ct. Apt 319 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 👿 No Black. White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Homemaker None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carrie McGowan Edward Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 Snowhill Ct. Sandra Queen(Daughter) Gambrills, Md. 21054 20a. Method of Disposition 20b. Hapelof Disposition (gaine of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 10-24-09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses A Mame Road Sept Pailit Sons Mortuary, P.A. MO0482 Harri 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alherosclerotic cardievascu Enysician/ disease or condition resulting in death) oyear Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown ed by the a detached t 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 \(\text{No} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident filled in by the 1 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

OHM/H 17 Flow 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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lestown-Not Number 6.3 4037 of Decedent 10b. County 10	ewhart Mill Sex 7. Ag 1 M 2 F 7. Ag ter ewhart Mill 12. Was Decedent Armed Forces? 1 M 2 Sey 1 Yes, Give Year or Dates: college (1-4or set) ialk, Jr. (Type. Print) /Wife	e (In yrs. last 62	birthday) Yrs. Mo own or Location alestown 113. Was If Yes 1	alesto Under 1 Year onths Days On Of. Zip Code 1997 Decedent of Is, specify Cut Yes 2 XNo 's Usual Occu of of work done NOT use retire Panel	3 Hispanic Origin, Dan, Mexican, P Specify: pation e during most of end) Board 18. Mother's	8. Date of Bin (Month, Date of Bin (Month, Date of Bin (Month, Date of Bin (Month, Date of Bin (Month, Date of Bin (Month, Date of Bin (Month))	4c. Coun Dorch th y, Year) 10g. Citizen o 14. Pi Spec 16b. Kind of Manufa	Mary I f What County JSA ace - America ack, White, 6 Sifty: White, 6 Business/Inc.	0d. Inside City Limits 1 ☑ Yes 2 □ No try? an Indian, etc. Lte dustry
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5 ☐ Other (Spec	city)		eterv. crematol	n (Name of	, Sharp	town, Mar		21861	
	A - 1/	10.1	stown (Cemeter	ry 10,	/24/2009 ome, P. O. East New			Maryland
er the disease, or coreant failure. List only se (Final tion tion) conditions, or immediate deriving and the conditions of the conditions	b	d the death. I	Do not enter the						Approximate Interval Between Onset and Death
lent pregnant 12 months? 2 □ No wn	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3□Ect	topic pregnan ther <i>(specify)</i>	су			Date of delive	ery Day Year
nificant conditions	contributing to death b	out not resultir	ng in the under	rlying cause g	iven in Part I.		,		he cause of death? pably 4 □Unknow
				-		per 1□ Yes	ormed? 2 2 No	prior to cou death?	opsy findings availab impletion of cause of
No-	Hospital: 1 ☐ Inpati	ient 2 ☐ ER	VOutpatient 3	3□ DOA O	thor			Other (Specif	······································
6 ☐ Could not	on be 28e. Place of in	ay Year) jury - At home	Injury	M 1]Yes 2 □ No	28f. Location	(Street and Nu		al Route Number,
	aminer: On the basis of	of examination							
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	eath 5 Pending investigati 6 Could not determine	Hospital: 1 Inpati 28a. Date of Inj (Month, Da	Hospital: 1 Inpatient 2 EP ath 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify) Lettifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury (Injury) 28c. Place of injury - At home, farm, street, building, etc. (Specify) 28d. Place of injury - At home, farm, street, building, etc. (Specify) 28d. Place of injury - At home, farm, street, building, etc. (Specify) 28d. Place of injury - At home, farm, street, building, etc. (Specify)	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Or eath 5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	ferred to medical Check only	ferred to medical Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Nucleigation 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and and manner stated.	ferred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specification for Injury at Work? 1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BEGUM **Physician** 2009 MIDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL ROCKVILLE MONTGOMERY GROVE SHADY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 XF None Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at GERMANTOWN 1 Myes 2 No **Funeral Director** MD MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 208 COMFREY 21203 AKISTAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian or other traumatic event, the Medical Examiner 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ASIAN Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 17. Father's Name (First, Middle, Last) -UD-DIN QURESHI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 NEPHEW 21203 COMFREY LN. GERMANTOWN MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
AL-FIRDAUS ME ARDEN 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If Iter
any injury or oth 10/25/09 1 Burial 2 Cremation 3 Removal from State FREDERICK 4 Donation 5 Dother (Specify) 22. Name and Address of Facility ADEN MUSLIM FUNERAL 21. Signature of Fungral Service Licensee SER. 1242 EASY ST. WOODBRIDGE VA-22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Hupertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOCTOR'S DRIVE GERMANTOWN MD. 20874 .19529 State Registrar

DHMH 17 Rev 1/2001

09-08127 Blake Boles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Director 515-90-3847 1 X M 2 F 23 Yrs. Months Days Hours Min. August 2 Usual Residence of Decedent 10a. State 10b. County Maryland Frederick Myersville 10c. City, Town or Location Myersville 10g. Street and Number 10g. St	4c. County of Death Frederick MM/DD/YYYY) 9. Birthplace (State or Foreign
4a. Facility Name (if not institution, give street and number) 3910 Highland Avenue 5. Social Security Number 515-90-3847 Usual Residence of Decedent 10a. State 10b. County 4b. City, Town, or Location of Death Myersville 7. Age (In yrs. last birthday) 4b. City, Town, or Location of Death Myersville 7. Age (In yrs. last birthday) 4b. City, Town, or Location of Death Myersville 16 Sex 7. Age (In yrs. last birthday) 4c. City, Town or Location 17 August 4c. City, Town or Location	4c. County of Death Frederick MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Kansas 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country? JSA 14. Race - American Indian, Black, White, etc.
Director 515-90-3847 1 X M 2 F 23 Yrs. Months Days Hours Min. August Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Foreign Country) Kansas 10d. Inside City Limits 1 Yes 2 X No Citizen of What Country? JSA 14. Race - American Indian, Black, White, etc.
10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No Citizen of What Country? JSA 14. Race - American Indian, Black, White, etc.
\$ W 1 1 1 D. 1 - 2 1 W 2 1	Citizen of What Country? JSA 14. Race - American Indian, Black, White, etc.
10g. Street and Number 10f. Zip Code 10g 3910 Highland Avenue 21773	JSA 14. Race - American Indian, Black, White, etc.
# # # Q	White, etc.
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3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done	Specify: WILLE 6b. Kind of Business/Industry
15. Decedent's Education (specify only highest grade completed) 16. Decedent's Education (specify only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Magnetic Completed) 18. Mother's Name (First, Middle, Magnetic Completed) 18. Mother's Name (First, Middle, Magnetic Completed) 18. Mother's Name (First, Middle, Magnetic Completed)	College
To Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Ma James Boles 18. Mother's Name (First, Middle, Ma James Boles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Name of Disposition 19b. Mailing Address (Street and Number or Rural Route Number of Disposition 19b. Mailing Address (Street and Number or Rural Route Number of Disposition 19b. Mailing Address (Street and Number or Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Number of Rural Route Number of Disposition 19b. Mailing Address (Street and Numbe	iden Surname)
To go by the second of the sec	
Donna Boles - mother 3910 Highland Avenue, Myersv	ille, Maryland 21773 20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State Stauffer Crematory 10-23-2009 Let a be a second state of the place	Frederick, Maryland
21. Sign ture of Funeral Service tacensee 22. Name and Address of Facility Stauffer Fundadow Address of Facility Stauffer Fundadow 1621 Opossumtown Pike, Free	neral Home derick. Marvland 2170
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresfailure. List only one cause on each line.	t, shock, or heart Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
Sequentially list conditions, b. Inhalation of Nitrogen Gas	
if any, leading to immediate cause. Enter throughing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
events resulting in death) Last Due to (or as a consequence of): d.	
events resulting in death) d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy	
O D D D D D D D D D D D D D D D D D D D	23d. Date of delivery Month Day Year
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 2 Fetal death 3 Ectopic pregnancy The past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.	acco use contribute to the cause of death?
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25. Was case ferered to medical examiner? 1 Ves 2 No 28. Pale of Injury 28. Injury at Work? 28. Injury at Work? 28. Injury at Work? 28. Injury at Work? 28. Injury at Work? 28. Injury at Work? 28. Injury at Work?	tesidence 6 🗸 Other: Scene
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to 1 1 Yes 24a. Was are autops; perform 1 Yes 2 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined County of the perform of the perform of the perform of the perform of the performance of the perf	ow injury occurred osefully inhaled nitrogen gas
Volume 1 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Stor Town, Street) 1 Natural 2 Accident 2 Natural 2 Natural 3 Validation 3 Validation 3 Validation 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Stor Town, Street) 28f. Location (Stor Town)	reet and Number or Rural Route Number, City ate) Avenue, Myersville, MD
29a. Certifier (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause making the state of the course of the cause of the course of the course of the cause	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)
O.C.M.E.	October 20, 2009
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) Registrar OCT 2 2 2009 32 Registrar's Signature	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 28, 2009 8:50 P M **Physician** Robert A. Bender /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/31/1920 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1⊠ M 2□ F 720-16-5943 88 New Jersev Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 771 Holly Drive North 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No WW If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert F. Bender Eva M. Blatz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank A. Bender - Son 771 Holly Drive N., Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore Crematory 9/30/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myelin 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical Due to (or as a consequence of): Examiner ancientic Comer Het astatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed/ 1 Yes 2 No certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 il or Attending Patter death.

Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43375 completed cause of death (Item 23a) (Type, Print) PKWY, Annapolis, MD. 21401 31. Date filed (Month, Da Registrar's Signature State sark Registrar

DHMH 17 Rev 1/2001

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			1 - State Registrar	State of Maryland		rtificate of L		, ,	Reg. No. 20 (09 35784	
	Physici		Decedent's Name (First, Middle, Last) Edward Reginald	Bloom				2. Date of Dea Month Septem	oth Day 1ber 29,	3. Time of Death Year 2009 1:55 AM	
	/Medic Examin								Arundel		
	Funeral Director		373-40-3002	7. Age (In yrs. I	If Under 1 Year Months Days			7, Year) 36	9. Birthplace (State or Foreigr Country) Canada		
yland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. I have seen that "ratural", or items 23a or 28a-f show umatic event, the Mourcal Examinari, and be redflied at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun		, Town or Lo	cation LS				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
			10e. Street and Number 20 South Cherry G	rove Avenue		10f. Zip Code 2140	1		10g. Citizen of W	hat Country?	
			11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	2. Was Decedent Ever in U.\$ Armed Forces? 1		Vas Decedent of H f Yes, specify Cuba I □Yes 2 🛣No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White	
			15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+) 5+	(Give life. L	lent's Usual Occup. kind of work done c DO NOT use retired ial Worke	during most of work I)	ding	State C	Sovernment	
		To Be C	17. Father's Name (First, Middle, Last) Emanuel Edward Bl	oom			18. Mother's Nam Gera	e (First, Middle, ldine Gr		?)	
, Mar	s 1 and 2 shou f Health and M tem 27 is mar other traumat		19a. Informant's Name/Relationship (Type Jennie Dunleavy Bl	,			and Number or Rui y Grove I			State, Zip Code) LS, MD 21401	
Банттоге,	P T		20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. P	ltimor	sition (Name of natory or other place e Cremato	ry 9/30	7,	Baltimor		
Dall	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	Chert						neral Home olis, MD 21401	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line. Due to (or as a consequ	3	er the mode of dyin	g, such <i>a</i> s cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
	rincate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Losses or injury that initiated events								
		ledical Ex	resulting in death) Last Due to (or as a consequence) d.			Jence of):					
	the death certify the attending Iched for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3 [Ectopic pregnancy Other (specify)	у		23d. Date Mon	of delivery th Day Year	
as, r	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions control	ibuting to death but not resu	lting in the ur	nderlying cause give	en in Part I.	23e, Did to		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown	
ı Records								24a. Was a autop: perfor 1 □ Yes	sy pi med? de	/ere autopsy findings available rior to completion of cause of eath? □Yes 2 □No	
VISION OF VITAL		o Be	25. Was case referred to medical examiner?	spital:	ER/Outpatien	t 3 DOA Othe	26. Place of Deat	th (Check only or	ne) lence 6 □Othe	r (Snecity)	
		ertification: T	27. Manner of Death 1 Death 1 Secondary 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurred								
2		Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)						r or Rural Route Number,		
		Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		N	29b. Signature and titudor dertifier	>		29c. Licenso	3) 4 \$ 6	2	29d. Date signed	(Month, Day, Year)	
D.	410		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print) Wh	Die	Chest	MA 3	2005	

State Registrar

OR Par

31. Date filed (Month, Day, Year) 32. Reg

's Signature b. Sake

Amend Items 27,28a-f per me, g89,7,11/06/09diffensure All Copies Are Legible.

1- State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 10/16/09 per Dr. Certificate of Death

Reg. No. 2009 35**785** 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 5, 2009 Year Physician 9:20 P M Norma Lorraine Bolten /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. Day, Year) 11, 1937 Year 1 □ M 2 🖾 F 72 518-40-3061 Colorado July Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show 1 ☐ Yes 21 No Director Maryland Montgomery Montgomery Village the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with then tof Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or it yor other traumatic event, the Medical Externing Installed. 10202 Kindly Court 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐Yes 2 ☑ No Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Reservation Agent Airline 17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Bolten / Husband 10202 Kindly Ct., Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. Oct. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature of Fund Service Luchsee 22. Name and Address of Facility
Resthaven Funeral Services, Skkot Cody P.A.
9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part I. Enter the disease, of shock, or heart failure. Life disease or condition resulting in death) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Pulnony Em belus **Physician** /Medical Due to (or as a consequence of): Examiner RICH Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Boul Ositule sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performe death? 1 □Yes 2 🗷 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) MXXYes -2 2/1 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hatural 2 Accident 5 Pending investigation 09/28/2009 **Unknown**_M 1 ☐Yes 2 K No Subject fell 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 10202 Kindly Court
Montgomery Village, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Home Montgomery Village, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner extends and manner extends. 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03H-5 Shahryar Davari, M.D. 10110 Molecular Drive, Suite #206, Rockville, MD 20850 31. Date filed (Month Day 32. Pagistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** žö, October 2009 3:00 p M Conover Meredith Gail /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, You Jan. 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday Year Months Days 1 □ M Jan. 1948 Seattle, WA 538-48-3465 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Montgomery Bethesda 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20814 USA 4311 Kentbury Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2**1 X**No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married White 1 ☐Yes 2x No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contract Administrator Department of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Helena Danielson Henry Calvin Conover 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4511 Highland Avenue, Bethesda, MD 20814 Daniel J. Lewis/Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2x Cremation 3 ☐ Removal from State Oct. 2009 23 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Prancis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 5 حصه 24 23a. Part1. En er the disease, or complications that caused t.k. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days Sepsis Due to (or as a consequence of): days Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2x No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 LaNo 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day, Year) 1X Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier *XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

and Box 68760, attending physician certificate be asn or Ö the ₫. þ signed I Division of Vital Records, has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this continuation. funeral filled in by the

Funeral

Director

show

with

death \

72 hours after

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If item 27 is marked other that many Injury or other transment

Physiclan

/Medical

Examiner

Maryland 21215-0036

Baltimore.

r than "natural", or items 23a or 28a-f shov the Wedical Examinar must be notified at

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State Registrar

31. Date filed (Month, Day, Year) 2009

30. Name and address of person who co Suresh K. Gupta,

and title of pertifier

29b. Signature

rson who completed cause of death (Item 23a) (Type, Print) Cupta, MD 9801 Georgia Avenue, #220, Silver Spring, MD 20902 . Registrar's Signa ure

29c. License number

D32332

29d. Date signed (Month, Day, Year)

October 21, 2009

State of Maryland / Department of Health and Mental Hygiene 35787 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 John Arnold Coleman, Sr. October 11:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1⊠ M 2□ F 213-01-7419 91 06/08/1918 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f show event, from Medical Examinations to envilled at 1 ☐ Yes 2 ☑ No Director MD Upper Marlboro Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8639 Trumps Hill Road 20772 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 录No White \$ Specify: 3 B Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ite Mus Elementary/Secondary (0-12) College (1-4or 5+) Sales and Service Business Machines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Bannon Coleman Elizabeth Arnold ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paige C. Sober (Daughter) 17800 Burbank Blvd. #106, Encino, California 91316 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brinsfield-Echols Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Sign Funeral Spryce Licensee

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2-3 chag Immediate Cause (Final **Physician** henmonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the nse yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has bletely filled in by the funeral director, page 2.9. autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 025230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Allen, M.D., 25500 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 0CT 2 8 2009 32. Registrar's Signature State Registrar

		_	For State of Marylar	· ·				20	00	25700
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of L	2. Date of Dea	Reg. No. 2009 35788				
Physician/			MARY B.	AIG		Month OCTOBER	Day	Year	3. Time of Death $11:09P^{M}$	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	- 011		Location of Death		4c. County		11.051
		WASHINGTON ADVENTIST HOSPITAL			TAKOMA PARK			MONTGOMERY		
	Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. 1 ☐ M 2 🛣 F 85	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Countr	ace (State or Foreign
	Director		578-32-9426 Usual Residence of Decedent	Yrs,			(Month, Day, FEB. 9	<u> 1924 .</u>	MARYL	AND
336	and show	Funeral Director		ty, Town or Loc	cation				10	d. Inside City Limits
	Maryl 28a-f otifie		MD PRINCE GEORGE'S UE	PER MAI	RLBORO					1 ☒ Yes 2 ☐ No
	h the	al D	10e. Street and Number		10f. Zip Code 2077	7 /1		10g. Citizen of W	/hat Countr SA	y?
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	To Be Completed by Funer	11318 KETTERING PLACE 11 Marital Status 12. Was Decedent Ever in U.	e 112 V		Ispanic Origin? (Sp	ecify Ves or No-		- America	- Indian
			1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	l II	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		k, White, et	c.
9	hours natura lical E		15. Decedent's Education 16a. Decedent's Usual Occupation					16b. Kind of Bu	. Kind of Business Industry	
Maryland 21215-0036	hin 72 ne. than "l		(Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+)	life. D	kind of work done (O NOT use retired) HER AID	during most of worl	king	GOV	ERNME	NT
2	ed wit Hygie other		17. Father's Name (First, Middle, Last)	TEMO	THER TIED	18 Mother's Nan	ne (First, Middle, M			
lan	should be filed h and Mental Hy 7 is marked oth traumatic event		WALTER SNOWDEN			JANI				
lary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)			and Number or Rui				
	and 2. Health em 27.		LINDA CRAIG/DAUGHTER			ING PLACE				LAND 20774
Baltimore,	Page 1 ament of hant of hant of hant. If ite		1 X Burial 2 Cremation 3 Removal from State	cemetery, cren	sition (Name of natory or other plac		Date	20c. Location -		
ᄩ	artmel artmel brtani injury		4 ☐ Donation 5 ☐ Other (Specify) RI		TION CEMI . Name and Addres	ETERY 10-	·24-2009 . B. JEN			
Ba	permit. Departr Importa	i y) TE /			OVER ROAL				20785
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between							
A. In	Physician/ Medical		Immediate Cause (Final disease or condition as a.	2/551	5					Onset and Death
	Examiner	iner	resulting in death) Due to (or as a consequence of):							
	ate be executed ohysician and the burial-transit		Sequentially list conditions, if any, leading to immediate Due to (or as a consecutive feature).							
		kami	cause. Enter Underlying Cause (Disease or linjury that initiated events c							
		dical Examiner	resulting in death) Last Due to (or as a consequence of):							
760	cate b physi s the b		d							
89	eath certifica attending ph I for use as tt	M/C	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy					23d. Date	23d. Date of delivery	
Box 687	death ne atte ed for	Physician/Me	1 Yes 2 No 4 Pregnant at time of		Other (specify)	y		Mor	nth [Day Year
P.0.	at the d by the etach	Phy	9 Unknown Part II. Other significant conditions contributing to death but not re	sulting in the u	nderiving cause give	ven in Part I.	23e Did to	hacco use contri	bute to the	cause of death?
ds, P	requires that the de been signed by the should be detached									
Division of Vital Records,	ne law rei e has be ige 2 sho	Completed					24a. Was a autop perfor	sy p med? d	rior to com eath?	sy findings available pletion of cause of
a H	ian: Th	Be C	25. Was case referred to medical examiner?		26. Pl	ace of Death (Chec		2 NO 1	Yes 2	LAJ NO
ξ	hysic his ce I direc	10	1 Yes 2 No Hospital: 1 Inpatient 2			er: 4 Nursing H	ome 5 🗆 Resid	ence 6 🗆 Othe	r (Specify)	
n of	ding P h. After t funera	Certificate:	27. Manne Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe ho	ow injury occurre	d	
Siol	Attend r death cctor:	rific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h			res 2 🗆 NO	28f. Location (St	reet and Numbe	r or Rural F	Route Number,
ΘŽ	tal or rs afte al Dire		4 Homicide determined building, etc. (Specify)							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1							
	To the within To the Complex c		29b. Signature and title of certifier MD		29c. License	e number	2	29d. Date signed	(Month, Da	ay, Year)
1	26		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA: Hm in A 12 Attracts MO 831, University Blue East Silves spy Mp 20903							
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign	lure de la la la la la la la la la la la la la)				
	Registr	ilî	OCT 2 6 2009 Denu & B. A							

DHMH 17 Rev 1/2001

Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 MHa,106,26,

Physi /Me Exam 1 - For State Registrar

10a. State

MD

Elementary/Secondary (0-12)

College (1-4or 5+)

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f show Iner must be notified at

n "natural", or Item: fedical Examiner r

Director

Funeral

ompleted by

The law requires that the death certificate be executed To the Hospital or Attending Physician;

Division or Vital Records, P.O. Box 68760,

8	Con	12	QUALITY CONT	TROL INSPE	CTOR CON	TINENTAL	CAN CO						
ent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (Fi		•							
ic ev	To B	GEORGE LEE CHISHOLM SR.		ELLEEN	ROBERTSO	N							
uma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Stree	et and Number or Rural Ro	oute Number, City or	Town, State, Zip Code)						
er tra		GEORGE L. CHISHOLM III/SO											
of the		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place	ace) OCTOB	ER 20c. Loc	cation - City or Town, St	ate						
any injury or other traumatic event, the once.		4 Bondion 6 Bother (opeony)	Place of Disposition (Name of cemetery, crematory or other place KESBURY METH	!	1	BINGTON, N							
any in		21. Signatura of Funeral Service Ligensee	22. Name and Addr	ress of Facility RAYM	OND FUNI	.SERVICE	P.A.						
4	4 7	23a. Part1. Enter the disease, or complications that caused the dea	0641 5635 WAS	SHINGTON A	V F I.A F	LA'I'A, MD	20646 oximate						
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		95. I 11/02/2004/04	opinatory annual,	Inten	al Between t and Death						
cian Iical		disease or condition resulting in death)		SEASE									
iner		Due to (or as a conse	equence oi).										
	e	Sequentially list conditions, it as a leading to introduct a leading to introduct a leading to introduct a leading to introduct a leading to introduct a leading to introduce a leading											
ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events											
ial-tre	Examiner												
as the burial-transit													
as th	Jed	d											
r USF at	an/h	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 3 □ Ectopic pregnancy											
o peu	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown											
detac		Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause of	iven in Part I.	23e. Did tobacco us	se contribute to the cau	se of death?						
d be	Completed by	COPD	No 3 Probably										
lnous	etec	MACETTACA				1							
ge 2	шb	HYPERTENSION			24a. Was an autopsy performed?	24b. Were autopsy fir prior to completion death?	dings available on of cause of						
r, pa	ပိ	POST POLLO SYNDROME			1□ Yes 2 No	1 ☐ Yes 2 ☐ N	lo						
recto	Be	25. Was case referred to medical examiner? 10 Vec. 24 No.	Ot Ot	26. Place of Death (Ci									
aral d	은 .	27. Manner of Death 28a. Date of Injury	□ ER/Outpatient 3 □ DOA □ DOA □ 28b. Time of Injury □ 28c. Injury	ther: 4 Nursing Home	5 Residence 6 Describe how injury	Other (Specify)							
fune	tion	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation		ork? ∃Yes 2 ⊟No	a country in the coun	, 555411.54							
y the	fica	3 Suicide 6 Could not be 28e. Place of injury - At	I I home, farm, street, factory, office		Location (Street and	d Number or Rural Rout	e Number.						
ed in b	Certification:	4 ☐ Homicide determined building, etc. (Spec	oify)		City or Tòwn, State)		,						
completely filled in by the funeral director, page 2 should be detached for use	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the nation and/or investigation, in my	time, date and place, and opinion, death occurred a	due to the cause(s) at the time, date and	and manner as stated. place, and due to the c	ause(s)						
com	Ž	29b. Signature and title of certifier	29c. Licen	ise number	29d. Date	e signed (Month, Day,)	'ear)						
		· Offi	0	12906	10	/26/09							
		30. Name and address of person who completed cause of death (Ite		1007	11 5	20606							
l l		Louis V. Kaufman, M.D., 1207	u uld Line Cent	re, #20/, W	aldori,MD	ZUOUZ							

State

Registrar

parked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2009 3:30 P M Sarah Ruffin Dischino 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign

Examiner Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medicel Examinar mat be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

Physician

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	426-54-987		1□M 2[X F	77	Yı	rs. Month	s Days	Hours	Min.	5/16/1			issippi	
	Usual Residence of 10a. State	Decedent 10b. County		100 Cit	. Town	or Logation							10d. Inside City Limits	
ō	MD	Frederi	ck		hurmo	or Location							1 ⊠Yes 2 □ No	
Je l	10e. Street and Nur		.CR		HULIIN		ip Code				10a C	itizen of What Co	ountry?	
al Di	23 Stone		ay			1	21788				US		ountry.	
nue	11. Marital Status		12. Was Deceder Armed Forces	?	S.	13. Was Dec	edent of H	lispanic Or an, Mexica	rigin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		
Be Completed by Funeral Director	1 □ Never Marri 3 🙀 Widowed		If Yes, Give 4	7		1 □Yes	2√ No	Specify	:			Specify: Wh	ite	
lete		cify only highe	it's Education st grade completed)		1 6	Decedent's Us Give kind of v life. DO NOT	vork done	durina mos	st of worki	ng	16b. Kind of Business/Industry			
mo:	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	1	Purchas		,			Electric			
Be C	17. Father's Name	(First, Middle,						18. Moth		(First, Middle		·		
2	John	Brown	Ruffin						Va	alllie	Mildr	ed Pitt		
	19a. Informant's Na John	ame/Relations Tackett	ship (Type. Print)			Mailing Addre				al Route Number, City or Town, State, Zip Code) ont, Maryland 21788				
		□ Cremation	3 ☐ Removal from Stat	e 1		Disposition (No crematory of				Vacco		_ocation - City or		
	4 Donation			Moc	rneac	Cemete 22. Name			11/03,	7 2009	MOC	rhead, MS	ad, MS	
	21. Signature of Fu	uneral Service	license	M014	33				,	.0. Box	287	Indi anol	a, MS 38751	
7	23a. Part 1. Enter t	he disease, or	r complications that caus	ed the deat	h. Do no							Interior	Approximate Interval Between	
	Immediate Cause	(Final	only one cause on each		a Ail e								Onset and Death	
	disease or condition resulting in death)	on	Due to (or a	s a conseq):							Days _	
			- 1	2500	Δ.	,							Years	
Jer	Sequentially list confirmed in the sequential sequence in the sequence of the sequence of the sequence of the sequence of the sequential sequence is sequentially list confirmed in the sequential seq	nditions, mediate	Due to (or a	s a conseq	uence of):							7.0.1	
mi	Cause (Disease or that initiated events	injury												
EX	resulting in death)	Last	Due to (or a	s a conseq	nsequence of):									
ca			d											
Med	IF FEMALE:													
an/l	23b. Was deceden in the past 12		23c. If yes, outcom			3 ☐ Ectopic	pregnanc	y.			23d. Date of delivery			
pleted by Physician/Medical Examiner	1 ☐ Yes -2-1 9 ☐ Unknown	No	4 ☐ Pregnant 9 ☐ Unknown		death	5 Other	specify) _					Month	Day Year	
Y Ph	_	ficant conditi	ons contributing to death	but not res	ulting in t	the underlying	cause giv	en in Part	1.	23e. Did	tobacco	use contribute to	o the cause of death?	
ed b	*									1 🗆] Yes	K No 3□P	robably 4 🗌 Unknown	
plet										24a. Wa		24b. Were a	utopsy findings available	
Com										per 1 □ Yes	opsy formed? N	death?	completion of cause of s 2 □ No	
Be	25. Was case refer	red to medica	1					26. Plac	e of Death	(Check only				
	examiner? 1 ☐ Yes 2	No	Hospital: 1 Thpa	tient 2 🗆	ER/Outp	oatient 3 🗍	DOA Oth	er: 4 🗆 N	ursing Ho	me 5 🗆 Res	sidence	6 ☐ Other (Spe	ecify)	
ation:	27. Manner of Deat 1 Natural 2 Accident	5 Pendir	28a. Date of Ir (Month, L gation	njury Day, Year)	28b. Tii !nj	me of jury M	28c. Injur Wor 1 🗆	yat k? Yes 2.⊑		28d. Describe	how inju	ury occurred		
Medical Certification: To	3 Suicide 4 Homicide	6 ☐ Could detern	ained 28e. Place of I	njury - At he etc. <i>(Speci</i> i	ome, farn fy)	n, street, facto	ory, office			28f. Location City or To	(Street a	and Number or R te)	tural Route Number,	
ical C	29a. Certifier (Check only	Certifyi	ng Physician: To the bes	of examina	owledge, ation and	death occurre	ed at the ti	me, date a	ind place, ath occuri	and due to th	e cause	(s) and manner a	as stated. e to the cause(s)	
Med	one)	I title of contific	and manner	stated.			Oo Linene	o number		1	204 D	lote signed (Mon	th Day Vaari	
-	29b. Signature and	T.O -	- AAO	29c. License number 29d. Date signed						O 7 8	09			
	30. Name and add	ress of person	who completed cause of	e of death (Item 23a) (Type, Print)										
	1475	70	peer Au	e,	F5	edes	riche	•	MI)	21	702		
e ar	31. Date filed (Mon	nth, Day, Year	6 2009 32. Regis	strar's Signa	ature	Bono	20							
			1000		1000	Mad Land								

ORIGINAL

Sta Registr

			State of Maryland / Dep. State of Maryland / Dep. Registrar Ce	artment of Health and l		ene _{1.No.} 2009 35792
	Physicia	an	Decedent's Name (First, Middle, Last) John Paul Daiger		2. Date of Death Month October	3. Time of Death 29, 2009 5:45 AM
j.	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
we f	Examin	CI	6812 Potomac Avenue	Braddock Heigh	its	Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	(Month Day V	9. Birthplace (State or Foreign Country)
	Director		218-32-7322 TAME TO SENSE TO S		July 14,	1937 Maryland
	yland how		10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
	e Mar Ba-f s	Director	Maryland Frederick Braddoo	ck Heights		1 □Yes 2XNo
	or 2		10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
	ns 23	Funeral	6812 Potomac Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21714 Was Decedent of Hispanic Origin? (S		United States 14. Race - American Indian,
9	after d or iten		1 Nover Married 217 Married 117 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 🛣 No Specify:	o Rican, etc.)	Black, White, etc.
03	iral",c	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1953	1 ☐ Yes 2 🖾 No Specify:		Specify: White
15-	"nate	lete	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)		6b. Kind of Business/Industry
212	l within giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Self Employed	He	eavy Equipment Sales
g	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural".	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Ma	aiden Surname)
yla	should b and Ment s markec umatic e	욘	Joseph Percival Daiger		a Smith	
Maryland 21215-0036	12sh thand 7 Isrr traum			ing Address (Street and Number or Ru		
	thealth tem 27 other to			Potomac Avenue, I	Date 20	Oc. Location - City or Town, State
altimore,	Pages nent of i		Burial 2 Cremation 3 Chemoval from State	110 4 C	mber 3, 009 F:	rederick, Maryland
	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic once.			22. Name and Address of Facility Beney and Basford		
<u> </u>	9 9 E P 9		MO14/3 10	06 E. Church Stree	et, Freder	rick, Maryland 21701
	Physician /Medical Examiner		Due to (or as a consequence of):	ner the mode of dying, such as cardia		Unser and Dearn
· ·	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			e e
8760	ate be nysicia ne bur	dical	d			
89	ertifica ling ph e as th	Med	IF FEMALE:			
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
٠ <u>.</u>	s that ined b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ğ	w requires that s been signed t should be deta	led t	Brain michighass		1 🗷 Yes	2 No 3 Probably 4 Unknown
al Records,	: The law recate has be page 2 she	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? ↑ 1 □ Yes 2 □ No
Vital	sician; The certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Other	ath (Check only one)	
ō	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at	ome 5 Residen 28d. Describe how	ce 6 Other (Specify)
ion	arth. rr; Aft	atio	1/2∰ Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No		
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	Hospi 24 hou Funer Fely fil	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 4 ☐ Medical Examiner: On the basis of examination and/or in and manner stated			
	o the outple omple	Mec	one) and manner stated. 29b. Signature and title of certifler	29c. License number	290	d. Date signed (Month, Day, Year)
	-> - 0		DZdon	D1156 26	5 0	Oct 29,2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)		de 29,2009
			21 Data filed (Month Day Vaci) 32 Photography Signature	w7 56	Fre	dr. 1 m 0 2170
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 6 2009 32. Begistrar's Signature	Some		

DHMH 17 Rev 1/2001

30 7K

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Louis Robert Dreyer October 23, 2009 3:45 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Montgomery Hospice-Casey House 8. Date of Birth (Month, Day Feb. 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 92 Yrs. 5. Social Security Number Year 1917 Funeral Days Hours Min Maryland 214-17-3143 1**★** M 2 □ F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Westical Evan struct by motified at 1 □Yes 2 No Silver Spring Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 USA 313 University Blvd., East Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
12 Yes 2 □ No
If Yes, Give
Year or Dates: 1943-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ğ 3x Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Printing Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Nice Milfred Drever ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40 Watertown Road, Berlin, MD 21811 Patricia A. Seidel/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott Oct. 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Francis Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Errier the disease, or complications that diused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Obstructive Pulmonary Disease resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year for Month Day 5 Other (specify) ☐Yes 2☐No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed has Be

Box 68760, attending physician certificate be O signed by ₫. Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,

the Maryland

within 72 hours after death with

Baltimore, Maryland 21215-0036

Certification: To

24 hours a To the I within 2 5+1

Medical

Hypertension, Es	ophageal Stricture	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown
		24a. Was an autopsy performed? 1 \[\text{Yes} \ 2 \] \] 24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \ 2 \] \] 1 \[\text{Yes} \ 2 \] No
25. Was case referred to medical	26. Place of D	eath (Check only one)
examiner? 1 ∐ Yes 2 ဩtNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 6 Mother (Specify) Hospice
27. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? M 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not l 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a, Certifier 1 **Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Kouetchou, 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive, Rockville, MD 20850 Jocelyne Kouatchou, MD

31. Date filed (Month, Day, Year) State 2009 Registrar



			For State Registrar	State o	f Marylan	-	artment of H		and M			200	9	357	94
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Dea				3. Time of Dea	ath
	Physicia /Medic		DENNIS TRAV	ERS DOZ.	Α					OCTOBE	-	5 2009		7:52p	M
	Examin		4a. Facility Name (If not institution, giv NATIONAL INSTITUTE 0		mber)		4b. City, Town, or BETHESD		of Death		4c.	County of D			
	Funeral Director		5. Social Security Number 6. S 496.46.0181	ex XXM 2□F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da DEC. 14	y, Year)		Country	ce (State or Fo	
	ס		Usual Residence of Decedent							DLC. 1-1	, 15-1	0 K			
	arylan show	r o	10a. State 10b. County		10c. City	y, Town or Lo							10d	. Inside City L 1 ☐ Yes 2 [
	he Me	Director	MISSOURI PERRY			PER	RYVILLE 10f. Zip Code				10a Citi	zen of What	Country		*X.
	with 1		10e. Street and Number 2151 HWY M				63775				J	SA	o o a mary	•	
	ms 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori	gin? (Sp	ecify Yes or No		14. Race - A			
ဖွ	or ite		1 ☐ Never Married 2 ☒ ¾ Married	Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2 XXNo		niyes, specity Cuba 1 ∐ Yes 2√√√ No	in, Mexican Specify:	i, Puerto	Hican, etc.)		Black, W Specify:	hite, etc		
00	ural",	d by	3 Widowed 4 Divorced	Year or Da	ates:						101 10	oleccione and	-04		
5	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the Modeal Exemi her must be metified at	lete	15. Decedent's Ed (Specify only highest gra	de completed)		i (Give	dent's Usual Occupa kind of work done o DO NOT use retired	durina mosi	t of worki	ing	160. KI	nd of Busine	ss/inaus	stry	
212	withi	Completed	Elementary/Secondary (0-12)	College (1 2	-4or 5+)		ARMER	,			А	GRICULT	URE		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Modell Exprision in the prefiled at	BeC	17. Father's Name (First, Middle, Last,	+				18. Mothe	er's Name	e (First, Middle,	Maiden	Surname)			
<u>yla</u>	should b and Ment s marked umatic e	To.	TRAVERS DOZA							NE WILSON					
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street a				er, City o	r Town, Stat	e, Zip C	ode)	
e)	s t and 2 should of Health and Mer item 27 is marke other traumatic		NANCY DOZA 20a. Method of Disposition	W!	20b. F	Place of Dispo	51 HWY . M ,	·		E MO 63 Date	775 20c. Lo	cation - City	or Tow	n, State	
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altimore,	permit. Page Department Important; II any injury or once.		21. Sign with Fun and Sarvice Licer	The second second	D MOOI		CEMETERY 2. Name and Addres	ss of Facilit	У			LIMITVIL		10	-1760-
m	e d La	1	K. KREGORY	FTNK	MO114	8	FINK FUNERA				IE. M	D 21061			
Е			23a. Part 1. Enter the disease, of com shock, or heart failure. List only	plications that c one cause on e	aused the deatl ach line.	h. Do not ent	er the mode of dyin	ng, such as	cardiac	or respiratory a	rrest,		l li	approximate nterval Betwee Onset and Dea	
1	Physician		Immediate Cause (Final disease or condition			plasti	c Syn	dron	ne				3	men	
	/Medical Examiner		resulting in death)										_	lance	
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c Ce,	rebro va	scolow	acci	dont	L					week	
Ö,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to	(or as a conseq	uencė of):									
8760	icate b physic the bi	dical		d									+		
9 X	eath certific attending p for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna							23d. Date of	delivery	1	
Box	death le atte	Physician/Me	in the past 12 months?		birth 2 ☐ Feta nant at time of c		☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	у				Month	D	ay Yea	ar
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ပ္ပ	aw requir is been s 2 should	Completed								24a. Was		24b. Were	autops	sy findings ava	ailable
Ě	/sician: The law s certificate has b lirector, page 2 s	Com								perfo	rmed? 2 DANo	deat	า?	Ľ X No	
<u> </u>	ician; certific ector,	Be (25. Was case referred to medical examiner?	Hospital:			Oth	or:		h (Check only o					
ō	Phys r this ral dir	٠ <u>.</u>	1 ☐ Yes 2 ☑No 27, Manner of Death	28a. Date	Inpatient 2 of Injury	ER/Outpatie	nt 3 🗆 DOA	4 L INI	ursing Ho	me 5 Resi			Specify)		
on	nding I tth. : After e funer	ation	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day, Year)	Injury		ḱ? Yes 2□	No		,	,			
Division of Vital Records,	tal or Attendii s after death. al Director: A ed in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	Zee. Place	of Injury - At he	ome, farm, sti fy)	eet, factory, office			28f. Location (City or To			r Rural i	Route Number	r,
	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certification properly filled in by the funeral director; prompletely filled in by the funeral director; prompletely		29a. Certifier + Certifying PI	nysician: To the	best of my kno	owledge, deat	h occurred at the tinvestigation, in my o	me, date a	nd place,	and due to the	cause(s	and manne	er as sta	ited.	
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(15)		30. Name and address of person who AMY PARKER RUHL	MD .	oe oi death (iter (9000 R	OCKVILLE	PIKE,	BET	HESDA,	MD 2	20892			
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature									
	Registr	ar	NOV U O ZUUS	Lang	1	//									

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Records, P.O.

Division of Vital

attending physician and for use as the burial-tran page 2 should be detached certificate director, this funeral After 24 hours after death. Funeral Director: A in by the filled

Physician /Medical

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Pages 1 and 2 should be filed within 72 hours after death

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Department of H Important: If ite any Injury or ot once.

Baltimore, Maryland 21215-0036

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be mutified at

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð OSTEOPURUSIS Completed POSSIBLE GASTROINTESTINAL BLEEDING 25. Was case referred to medical examiner? Be 1 Yes ≥ No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Qay, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

Helen A. Noble, 31. Date filed (Month, Day, Year)

M.D. 122 Speer Rd. Chestertown, MD. 32. Registrar's Signature arkas

NOV 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiens 35796 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:55 PM Jesse L. Emory 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOGERSTOWN, MD U

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) washington Julia Manor 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 219-68-0142 Director 54 10/05/1955 Waynesboro, PA Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "naturel", or items 23s or 28e-f show the Medical Examiner must be notified at Yes 2 No MD Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US 333 Mill St. 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No white Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) never worked nd 2 should be filed it lith and Mental Hygic 27 ie marked other r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cletus W. Emory Josephine I. Bowman Pages 1 end 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21719 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s Depertment of Health an Important: if item 27 ie any injury or other trau 14310 Pen-Mar High Rock Rd. Cascade, MD Cindy Wiley P.O. Box 81 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Bethel Church Cemetery 11/4/2009 Cascade, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Grove-Bowersox Funeral Home, In 50 S. Broad St. 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Waynesboro, PA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Cell carcinoma with metastasis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Hospital Nurse Practitioner Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the ! and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/1/2009 RIZSUSS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 333 Mill St. Hogerstown, MD 21740 CRNP

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 6 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Warren L. Eisenbraun October 28 2009 2110 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Haure (de Grace Harford Memorial Hospital Harkord 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**火**□ M 2 □ F Days Hours Director South Dakota 504-30-0358 03/01/1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 1 □Yes 2 No Director MD Harford Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 230 Oakington Road S.A. Funeral 21078 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√2 No Specify. ۾ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Finance Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Emil Eisenbraun Amanda Krueger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natasha Drew (Daughter) 17 Gettysburg Drive, Nashua, NH 03064 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Co. Inc. 11/02/2009 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. 21 Signatul of Funeral Service Licensee 123 S. Washington Street, Havre de Grace, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANOXIC BRAIN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STATUS Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Yes 2 No 1 ∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Records, P.O. certificate has of Vital funeral di ector, After this Division

Baltimore, Maryland 21215-0036

1 Yes 2 No

27. Marrner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide

29a. Certifier (Check only Hospital 1 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D0069118

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KhALID Puth AWALA 5015, UNION HAURE de GRACE, MA 21078 31. Date filed (Month, Day, Year) 32. Registar's Signature

State Registrar

within 24 hours after death.

To the Funeral Dire tor: A completely filled in b the fu

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Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month OCT 8:25 PM Edith Helen Erlick 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/18/1918 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🖺 F Days Hours Min. 017-22-7203 91 Director Massachusetts Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1ÆYes 2 □ No Funeral Director MD Montgomery Silver Spring Pages 1 and 2 should be filed within 72 hours after death with the neath and Mental Hygene.
ant: If Item 27 is marked other Itan "natural", or items 23a or 28a ant: If Item 27 is worked the wind the worked the unity or other traumatic event, the Medical Examiner must be notified. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1020 Kathryn Road 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Stone Rebecca Silbert ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Goldberg-Daughter 1020 Kathryn Road Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Gdns 10/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Chapels, Inc. M0163 23a. Fartt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENT /Medical Due to (or as a consequence of): Examiner EREBRO VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ATRIAL FIBRIL ATION Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 40 Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 2 No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 dursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ospital c.
4 hours after death...
-ral Director: Aftr 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or To the Hospital
within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

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29b. Signature and title of certifier

MONTROSE

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORZAN

26 2009

29c. License number

ROAD

ROCKVILLE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 23, 2009 Joseph Allen Ecker 5:10 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In vrs. last birthday) Funeral 1 **₹** M 2 □ Days Hours Min. (Month, Day, Year)
July 1. 1940 213-38-0010 69 **Director** Usual Residence of Decedent if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 USA 116 Woodridge Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postal Service University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ina Davis Nelson Ecker should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
116 Woodridge Avenue, Silver Spring, MD 20901 1 and 2 so of Health a item 27 i Johanna M. Ecker/Wife Date 25, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 2009 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ISCHEMIC MOUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CEREBRO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and attending physician for use as the buria Physician/Medical MYELOMA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PONTANEOUS LEFT PNEUMOTHORAX - STATUS-POS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? TUBE 24a. Was an THORACOSTOM has autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Tyes 2 HNo filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After t completed

DHMH 17 Rev 7/2009

State

Registrar

Medical

29a. Certifier

(Check

31. Date filed (Mo

VASHINGTON

30. Name and address of person who completed cause of death (item) 23a) (Type, Print) 7600 CHEFOLL HUSYLE

Registrar's Signatu

ALEMA

26

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: (in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HDUENTIST

TAROMA PARK, MO

34

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 state AMEND#19a, 20loperFH, 10/26/09, EMN, McCoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11:00^{P M} October Irene Finney 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery

9. Birthplace (State or Foreign Country) Shady Grove Hospital Rockville
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F Days Min. Hours 132-24-4841 26, Director 75 Oct. 1933 Unknown Usual Residence of Decedent 10d. Inside City Limits Show 10c. City. Town or Location 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Maryla.
Af Healith and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show other traumatic event, the feeling Examiner must be anothered. 1 XYes 2 □ No Maryland Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Valley Road 20850 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Unknown <u>Unknown</u> 19a. Informant's Name/Relationship (Type Print)
Social Worker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aida McCann/Other Potomac Valley Road; Rockville, MD 20850 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/26/09 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused t shock, or 'e rt failure. L'st only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Pneumonia 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician hed for use as the buria Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☒No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 HInknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 🖾 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) caminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20892 Paul Dickstein, M.D. 9000 Rockville Pike #15 Room #204; Rockville, MD Daniel 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar OCT 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alvin Greene October 12, 2009 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Season Hospice at Northwest Hospital Randallstown 8. Date of Birth (Month, Day, Sept. 5 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X** X M 2 □ F Months Hours Min. 81 Mary land Director 216-24-1831 Sept. 928 Usual Residence of Decedent show Baltimore er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location Randal Istown 10d. Inside City Limits Director 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with USA 21236 4021 Taylor Avenue filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2 🗓 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) automotive mechanic Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked o ည Frank Rudolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 4021 Taylor Avenue, Baltimore, MD 21236 Deborah Youngbar/stepdaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4X☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licenses ▶ Ronald S. Wade, Director per DV 655 W. Baltimore Street, Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to jor as a consequence of thany leading to instructional cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be en 124 hours after death.
E Funeral Director: After this certificate has been signed by the attending physicial leted filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar autopsy death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? and sold Other: 4 \square Nursing Home 5 \square Residence 6 $ot\!{N}$ Other (Spec 2 🗶 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Sulcide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and le of ce 29d. Date signed (Month, Day, Year) 30. Name and address of p o. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harold Bob, 25 Main Street, Reisterstown, MD 21136

DHMH 17 Rev 7/2009

State

Registrar

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egistrar's Signature

0 5 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 35803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3:40 P M Cecelia Regina Gatton October 25, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🕱 F 80 218-26-5410 Director December 31,1928 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show tre Medical Examiner must be notified at Director 1∭XYes 2 🗀 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 39613 St. Mary's Street 20650 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 2 👿 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1∐Yes 2k∏No White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any lipiry or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pilkerton ည Florence Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Everett Gatton / Husband 39613 St. Mary's Street Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t X Burial 2 ☐ Cremation 3 ☐ Removal from State October 29, Leonardtown, Maryland Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signedure of Funeral Service Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 -jardener Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** iai. /Medical Due to (or as Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fo The law requires that the death certificate be executed Exami and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? uting to death but not resulting in the underlying cause given in Part I. Records, pe 1 🗌 Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? After this certificate of Vital 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) James P. M.D 21585 Peabody Street Leonardtown, MD 20650 larboe, 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35804 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month GEBALLA 655 ٥ /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death 109 Main Avenue, S.E. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 9. Birthplace (State or Foreign Date of Birth (Month, Day, Days Months 1**Z** M 2□ F Hours Min. Director 163-24-6528 79 26, Dec. 1929 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to them 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Directo 1 ☐ Yes 2 No Anne Arundel Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Main Avenue, S.E. 21061 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Analyst Federal Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Leo Lawrence Geballa Julia Novotney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Geballa/Wife permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. 109 Main Avenue, S.E., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 10/23/2009 Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 er 106 Main Street, East New Market, MD 21631 2 a. Paul 1. Enter the disease, or complications that shock, or heart failure. List only on cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cus y serry /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause Cause) that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4 Unknown page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, within 24 hours after deat To the Funeral Director:

Registrar

(Check only one)

MICH AGR

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person

441

ho completed cause of death (Item 23a) (Type, Print) M

32. Registrar's Signature

DEFENSE HIGHWAY ANNAPONIMOZIKO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar 35805 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death october 20, 2009 Dorothy May Guderiohn **Physician** 12:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arden Courts of Pikesville Pikesville Baltimore County 8. Date of Birth (Month, Day, Ye Nov 10, 9. Birthplace (State or Foreign Country)
1928 New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 217-26-8642 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination must be notified at Maryland Bel Air Harford Director 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 United States 2010 Churchville Road, Unit 3 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐Yes 2X No Specify: þ 3 X Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) telecommunications PBX clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Rohart Sarah Stafford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 1611 Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type. Print) Larry W. Guderjohn - son P.O. Box 1611 permit. Pages 1 and Department of Healt Important; if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date Oct. 25 2009 Ž4, 1 🎇 Burial 2 🗌 Cremation 3 🔲 Removal from State Sykesville, Maryland Lake View Mem. Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home Hampstead, Maryland 21074 934 South Main Street M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Month STage /Medical Due to (or as a consequent e of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No LIVING 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

The law requires that the death certificate be executed physician the attending p for use as use as P.0. the þ Division of Vital Records, certificate has page 2 funeral director, After this Hospital or Attending To the Hospital or Attentomes within 24 hours after death.

To the Funeral Director: Aff

72 hours after

Health and Mental Hygi

should be

Maryland

Baltimore,

20 am 21215-0036

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> State Registrar

(Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT,

32. Registrar's Signature

31. Date filed (Month, Day, Year)

09-08400 Joy Gilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

by Gilson		State of Ivial yland / E	Certificate of		Reg.	No. 20(9 3580
Physicia ledical Exami	in/	1. Decedent's Name (First, Middle,Last)			2. Date of Death Month October 29,	ay Year	3. Time of Death 1832 hrs
eulcai Examii		4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of I		4c. County of Death	
		Peninsula Regional Medical Center		Salisbury		Wicomico	
Funeral Director		216-56-1003 1 M 2 XF	n yrs. last birthday) 57 Yrs.	If Under 1 Year If Under 2 Months Days Hours	24Hrs. 8. Date of Birth Min. 08/12/1	MM/DD/YYYY) 9. Bird Foreig 952	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Locati	on			10d. Inside City Limits
8 4	5	Maryland Somerset		Crisfie	1d		1 Yes 2 X No
Maryla r 28a-f		10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coul	ntry?
tith the l 23s or 2 notifie		26908 Old State Road 11. Marital Status 12. Was Decedent Ev	verin U.S. 13. Wa	21817 s Decedent of Hispanic Origin	n? (Specify Yes or No-	USA 14. Race - Ameri	ican Indian, Black,
0036 within 72 hours after death with the Maryland given than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Fune	1 Never Married 2 V Married Armed Forces?	No If Y	es, specify Cuban, Mexican, F Yes 2 X No specify:		White, etc.	hite
ours af atural	d by	15. Decedent's Education (Specify only highest grade complete	eted) 16a. Deceden	t's Usual Occupation (Give kir		6b. Kind of Business/	Industry
5-0036 led within 72 hours after Hygiene. other than "natural", the Medic 1 x, miner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during in	Ů	se retired)	Orm Ho	mo.
-003 d withing giene.	mo	12 17. Father's Name (First, Middle, Last)		Homemaker 18.Mother's	Name (First, Middle, Ma	Own Ho	e
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	Melvin Harris			le Culberts		
	٤	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Numb			
and 2 sho eafth and tem 27 is		Ronald L. Gilson (Husband) 20a. Method of Disposition	20b. Place of Dispos	ition (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State			11/05/2009	Salishury	Maruland
altin nit. Pa partmet portan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses	Salisbury	Crematory Name and Address of Facility		SONS FUNE	
E. T. P. W.		Mary Bath Brackstow Fro E23a. Part I. Enter the disease, or complications that caused the	30	6 W. Main Str			
Physician /Medical		failure. List only one cause on each line.					Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	paroxetine uence of):	and alprazola	ım intoxica	tion	5000
	١. ا	Sequentially list conditions, b	,				
	ine	if any leading to immediate Due to for as a consequence. Enter Underlying Cause	uence of				
red	Examiner	events resulting in death) Last Due to (or as a consequence)	uence of):				
760, icate be executed physician and the burial - transit	Medical	MENDED AMENDED	27 280 f p	erME, g899 1/2	20/10 TT		
760, cate be physic the bur		IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of delive	-
Box 687 c death certific the attending p	cian	past 12 months? 1 Live birth 4 Pregnant at til		etal death 3Ectopic ther (Specify)	pregnancy	Month	Day Year
Box e death the atte	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown					
P.O. Box 687 ss that the death certiff. gned by the attending i	by P	Part II. Other significant conditions contributing to death t	but not resulting in the	underlying cause given in Par		2 ✓ No 3 Pro	obably 4 Unknown
ords, P	ted				24a. Was a		utopsy findings available
COr law re has b	Completed				autops	med? death?	completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be an early or the funeral director, page 2 should be a should be		25. Was case referred to medical		26 Place of Death (W NO	les 2 No
Vita nysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatien	t 2 ER/Outpatier			Residence 6 Oth	er:
1 of V Jing Phy. After the		27. Manner of Death 1 Natural 5 Panding 28a. Date of Injury (Month, Day, Yes	$^{\prime}_{ar} FD = Fd$	Injury 28c. Injury at Work?		ow injury occurred	
ivisior or Attend after death Director:	catic	2 Accident Pending Investigation 10/28/20	009 8:35 a	eet, factory, office building, etc	28f Location (S	treet and Number or F	Rural Route Number, City
Divi	Certification:	3 Suicide 6 X Could not be determined (Specify)	house	,,, ,	or Town, Si Crisfie	ate)26908 01 1d, MD	d State Rd
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my Medical Examiner: On the basis of exam	knowledge, death occi	irred at the time, date and pla ation, in my opinion, death occ	ce, and due to the cause	e(s) and manner as sta	ated.
To with	Me	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (M	lonth, Day, Year)
		Mayrie Mr. Ukrell		O.C.M.E.		November 1, 20	009
		30. Name and address of person who completed cause of de Margarita Korell MD. Assistant Medical E		Penn Street, Baltimore	, MD 21201		
2	tate						
Regis		NOV 0 6 2009 Janua	s Signature				
		140.					

State of Maryland / Department of Health and Mental Hygiene 35807 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Marvin C. Gunter 2009 October 20, 2:14 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 30410 Cannon Drive Salisbury | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O1/14/1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 215-38-1043 Alabama 68 Yrs. Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Worldon Evar. incrines be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ∏Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30410 Cannon Drive 21804 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Giv**AirForce** Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Be Completed by 3 Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) welder welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawson Gunter Minnie Copper ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30410 Cannon Dr., Salisbury, MD 21804 Carolyn Gunter/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death END-STAGE Immediate Cause (Final COPP (CHASHIC OASTRUCTIVE **Physician** PULHOUMY Y the disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SMOKING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the deeth certificate be executed the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 TNo 9 Unknown Š After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by METARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe EVEN ONGESTIVE 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐ Yes 2 No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 4 hours after death. death. 1 ☐ Yes 2 ☐ No 2 Accident npletely filled in by the 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 29a. Certifier Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 58662 INTERM ST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 = State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician/ Month 2315 M Morner 29 2009 harles Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 7/31/1925 1 ☑ M 2 □ F WEST VIRGINIA 235-32-0083 84 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director 1 Yes 2X No BERKELEY HEDGESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 274 BORDER DRIVE 25427 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
PRESBYTERIAN PASTOR (Specify only highest grade completed) RELIGION Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CHARLES LOWRY HORNER JENNIE DUTROW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REV. DAVID L. HORNER/SON 2125 MARCONI COURT, WEST LAFAYETTE, IN permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition остовет 30, 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, les M. 327 W. KING STREET, MARTINSBURG, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) espiratori Medical consequence Examiner Bronchios asm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) use as the burial-transit Pleural Effusion that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been siç r, page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? Hospital or Attending Physician: The 1 Yes 2 No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ဂ္ 1 🖊 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After t 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To try best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed Month. Dav. Year)

State Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

week

MD

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32. Registrar's Signature

2009

Hagerstown, MD

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21742

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death
31 M 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 09 **Physician** ORNE ONEICE ΛÜ 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3604 HILLARY STREET PRINCE GEORGE'S UPPER MARLBORO 8. Date of Birth (Month, Day, JULY 29 Birthplace (State or Foreign Country)
 MARY LAND 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days 1 □ M 2 🗗 F Months 1983 Director 213-08-7674 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Marked Examiner must be notified at 1 Yes 2 □ No Director MD PRINCE GEORGE'S UPPER MARLBORO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3604 HILLARY STREET 20772 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married ☐Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 No BLACK Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) DISABLED NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOVE A. HORNE SHERIDA DOWING ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 3604 HILLARY STREET UPPER MARLBORO, MARYLAND 20772 LOVE HORNE / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State HARMONY CEMETERY 10-27-09 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Fulleral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE YY nte filed (Month, Day, Year OCT 2 6 2009 32. Registrar's Signature State Registrar

		For State	Please 1	Type or P State of		d / Depa	artmen	t of H	lealth a				_	ble.		_
Physicia	an	Registrar	e (First, Middle, Last William	Han	pol	Cei	rtificate	e or L	Jeath		2. Date of De Month	Reg. No.) () 9 Year	3 5 8 3. Time of Death	0
/Medic Examin			If not institution, give COUNTY G	street and numb	per)	AL		Town, or	Location of	of Death	00.1	4c.		of Death	101	
Funeral Director		5. Social Security N 214-52-4	4890 X	x] M 2□ F	Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D SEPT 2	ay, Year)	48	Coui	place (State or Foreign htry) HINGTON, DO	
Maryland f show	ŗo	Usual Residence of 10a. State	10b. County HOWARD			y, Town or Lo								1	0d. Inside City Limits X☐Yes 2☐No	
h with the 13a or 28a-	al Director	10e. Street and Nu		OWS WAY		LOPIDIA	10f. Zip	Code 2104	5			10g. Cit		en of What Country?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modicial Examples must be muitled at once.	by Funeral	11. Marital Status 1	ried 2 Married	12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No		Was Deced If Yes, spec 1 □Yes 2		ispanic Ori in, Mexicar Specify:					ck, White,	ce - American Indian, ck, White, etc. v: BLACK	
d within 72 hogiene. grene. er than "natur tre Medicel	Completed	(Special Special 15. Decedent's Edu cify only highest grad ondary (0-12)	cation le completed) College (1-4	or 5+)	(Give life.	dent's Usua kind of woi DO NOT us RSE T	rk done d se retired	during mos I)	t of work	ing	16b. K	ind of B	lusiness/In	VATE		
ould be filed I Mental Hyg narked othe natic event,	To Be C	WILLIAM	(First, Middle, Last) HARRIED							GEI	e (First, Middle RTRUDE	BR	OWN			
1 and 2 sh Health and tem 27 is m			lame/Relationship (7) ARRIED/SIS		20b. P	4311	23rd	PAR	KWAY	TEMI	al Route Num PLE HII Date	LS,M	ARYI		20748	
mit. Pages bartment of bortant: If it injury or o		4 ☐ Donation	Cremation 3 ☐ I 5 ☐ Other (Specify, weral Service Licens	1	ate	VERDAL	-	MATO	RY		2/2009 J. B. J				MARYLAND AL HOME	_
permi Depa Impo any ir		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											YLAND	Approximate Interval Between		
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. http://death.com/literary.co												Onset and Death 36 how Many Year		
ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):) }			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	2 months?	23c. If yes, outco 1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknov	⊒Ectopic p ⊒Other <i>(sp</i>		у					ate of deliv	rery Day Year			
quires that en signed b uld be deta	þ	Part II. Other signi	ificant conditions co	ntributing to dea	1,	ulting in the u		ause giv		l.		_			the cause of death?	/n
: The law re icate has bed , page 2 sho	Completed	- 000	te renal	Failure	· /		-				per	is an opsy formed?		. Were autoprior to condeath? 1 □ Yes	opsy findings availab ompletion of cause of 2 집사이	le
nding Physician th. : After this certif e funeral director	ation: To Be	25. Was case referexaminer? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident	₹No	28a. Date of	patient 2 Injury , Day, Year)	ER/Outpatie 28b. Time o Injury		28c. Injur Worl	er: 4□N	ursing Ho	th (Check only ome 5 Re 28d. Describe	sidence			ify)	
tal or Atterns after deal Directored in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place 0	f Injury - At ho g, etc. <i>(Specil</i>	ome, farm, st	reet, factory	y, office			28f. Location City or T	(Street a. own, Stat	nd Num e)	nber or Rui	ral Route Number,	
the Hospil hin 24 hour the Funer mpletely fill	Medical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam		sis of examina		nvestigation	n, in my c				e, date an	d place	, and due		
7 wit		29b. Signature and				7 (Tues			0 6	6511			o c		0 Z009	
6 Sta	ite.	30. Name and add	Itess of person who of AA (AA)	NAT	MD	10		ITTL	E PAT	ruxE1	NT PKWY	COL	UMB :	IA,MA	RYLAND 210)4
Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october 21, 2009 **Physician** Patrick Francis Healey 10:22 р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery General Hospital Montgomery 8. Date of Birth (Month Bay, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday, **Funeral** 577-34-6372 80 Months Days Hours Min. 1 **X** M 2 □ F Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show ed other than "natural", or items 23a or 28a-f shove event, the Wedical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Hawkesbury Terrace 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1953–56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married if Yes, Give Year or Dates: 1 ∐Yes 2 🛣 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Appraiser Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: It Item 27 is marked any injury or other transmitted William Leo Healey Rose Stanislaus McGovern မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth M. Healey/Wife 612 Hawkesbury Terrace, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State October 23 2009 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Euneral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Perforated **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Due to or as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-trans and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the detached f 9 Unknown signed l I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has t page 2 s autopsy performed' 2 No 1 □ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

be executed Ö ۵. Records, Division of Vital 0/26-0K

Per charlotta

within 72 hours after

Mental

Baltimore, Maryland 21215-0036

peen certificate l After this eral Director; f within 24 hours a

To the Funeral C

15+1

Differ 7/le S. Shan	D24190	October 22,20
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or control on the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, and due to tigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. ne, date and place, and due to the cause(s

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

3 Suicide

4 Homicide

tethue Fleboduard 12 3416 Olandwood Ct Olney Haryland 20832 31. Date filed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

Physician

State Amended ite Registrar 1. Decedent's Name (First, Middle, L		, оьU , I (· Cer	tificate of	Death	10	Reg	g. No 2	009	35812
	, .	3.	Hol	obs				15,	2009 Year	11:20 p ^M
. Facility Name (If not institution, g)			or Location of De	eath		4c. Co	unty of Dea	th
	Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year	If Under 24 H	rs. 8	Date of Birth (Month, Day,	Year)	9. Bir	thplace (State or Foreign
219–07–1366	1□M 2 X F	96	Yrs.	Months Days	Tiouis M	<u> </u>	1/30/19	12		ryland
sual Residence of Decedent ra. State 10b. County		10c. City, T								10d. Inside City Limits
Maryland Wicom	ico	Frui	tland	,						1 X Yes 2 □ No
e. Street and Number 206 W. Main St	reet			10f. Zip Code 2182	6		10	g. Citizer US A	n of What Co	ountry?
. Marital Status	12. Was Decedent Armed Forces	?	13. V	las Decedent of Yes, specify Cul	Hispanic Origin? Dan, Mexican, Pu	(Speci erto Ri	ify Yes or No- can, etc.)	14.	Race - Ame Black, Whit	erican Indian, e, etc.
1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced			Specify:			Sp	.,	white		
15. Decedent's (Specify only highest of	Education	1	6a. Deced	ent's Usual Occu	pation	varkina	10	6b. Kind	of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	and of work doing O NOT use retire Stress	ed)	· or miry		shir	ct fac	torv
12 7. Father's Name (First, Middle, La	st)		Sedill	967 G99	18. Mother's N	Name (First, Middle, Ma			COL I
John Byrd Butle	•				Bess:	ie V	Vest			
9a. Informant's Name/Relationship James B. Hobbs/			19b. Mailin	g Address <i>(Stree</i> Slab Bri	t and Number or dge Rd.	Rural i	Route Number, Cuitland	City or To	own, State, 2182	Zip Code) 6
0a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of	ice)	Dat		0c. Loca	tion - City or	Town, State
1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		W1CO Pa		Memoria!	10	/19	/09	Sali	sbury	, MD
21. Signature of Funeral Service Lie	Sentee	SP	22	Name and Addr HOLLOWay 501 Snow	ess of Facility Funera Hill Ro	l Ho	ome Proj Salisbi	fess:	ional MD 21	Association .804
23a. Part 1. Enter the disease, or co shock, or heart failure. List on	implication, that cause ly one cause on each I	d the death. I								Approximate Interval Between
mmediate Cause (Final disease or condition	a			Demen	ra					Onset and Death 5 Y COV
esulting in death)	Due to (or as	a consequen	ce of):	Demen Aso	VD.					loyears
Sequentially list conditions, any, leading to immediate duce. Enter Underlying	b Due to (or as	a consequen		, - 0	.)					1
Cause (Disease or injury hat initiated events esulting in death) Last	с								-	
eschang in death) Last	Due to (or as	a consequen	ce of):							
F FEMALE:	220 14	of preserve	,							
23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant	2 Fetal de	ath 3	Ectopic pregnar Other (specify)	су			230	d. Date of de Month	livery Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	a. ano oi ucai	JL	Carer (apeciny)						
art II. Other significant conditions	s contributing to death	out not resultin	ig in the un	derlying cause g	ven in Part I.		1	L 6		o the cause of death?
							1 ☐ Yes	/		robably 4 🗌 Unknown
				· · ·		_	24a. Was an autopsy perform 1 □ Yes 2	ed?	death?	utopsy findings available completion of cause of s 2 \(\sumbox{No}\)
5. Was case referred to medical examiner?	1524-7	,				Death (Check only one	1		
1 Yes 2 No 7. Manner of Death	Hospital: 1 Inpat	ient 2 ER	Outpatien	. 0000	·		e 5 Tesider		Other (Sp	Hospice Home
1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	ay, Year)	Injury	28c. Inj Wo M 1 [aryat ork?]Yes 2.∏No	20	G. Describe 110V	· ngury C	,ooureu	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ha	jury - At home tc. <i>(Specify)</i>	, farm, stre	et, factory, office		28	If. Location (Stree City or Town,	eet and I State)	Number or P	dural Route Number,
	Physician: To the bestaminer: On the basis and manner s	of examination								
29b. Signature and title of certifier				29c. Licer	ise number					th, Day, Year)
N nah					05/35	PA .		n . 1.	1-0- 1	615 2009

Registrar

State

1415 S. Division Street Ste B Salisbury MD
32. Registrar's Signature A. Sparks

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and aduless of Linkshall Nates an MD 31. Date filed (Month, Day, Year) OCT 2 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oward Hagen,		State of Maryland / Department I-For State Certificate Registrar		yglene Reg. N	lo. 200	0 2501
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da October 19, 2	y Year	3 Time of Death U 1 1827 hrs
ledical Exami	ner	Howard D. Hagan, Jr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		2009 4c. County of Deat	
		9140 Liberty Road	Frederick		Frederick	,
Funeral Director		210-88-1019 = 40	If Under 1 Year If Under 24Hrs Months Days Hours Min		M/DD/YYYY) 9. Bi Forei 1969	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation			10d. Inside City Limits
Aaryland 28a-f show 1 at once	į	Maryland Frederick Frederic	10f, Zip Code	1100	Citizen of What Cou	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	9140 Liberty Road	21701		nited Sta	-
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Manel Hygies within 72 hours after death, with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	neral	11. Marital Status 1 Never Married 2 Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		rican Indian, Black,
after de al", or	by Fun	or Dates:	Yes 2 X No specify:			nite
2 hours "natur			dent's Usual Occupation (Give kind of most of working life. DO NOT use reti		b. Kind of Business	/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: I firem 27 is marked other than " injury or other traumatic event, the Medical	Completed	10	Laborer		H.M.F Pay	ing Co.
15-C filed v I Hygi d oth		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
212 uld be Menta marke	To Be	Howard D. Hagan Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or	n Bruchey Rural Route Number	, City or Town, Stat	e, Zip Code)
MD d 2 sho lth and n 27 is		Howard D. Hagan Sr. / Father 9140	Liberty Road, Fr	ederick.	Maryland	21701
ore, s l and of Heal If iten			position (Name of cemetery, other place)	Date 20	Dc. Location - City o	r Town, State
Baltimore, permit. Pages I an Department of He Important; If ite		4 Donation 5 Other Specify: Glade Ce	metery 10/	23/2009	Walkersvi	11e,Marylan
Ball permit Depar Impor injury		21. Signature of Funeral Service Licensee	2. Name and Address of Facility tauffer Funeral H 621 Opossumtown P	omes P. A	oriol: Ma	121702
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical vaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular [Due to (or as a consequence of):	Disease			Death
		Sequentially list conditions, b				
	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed nsit	Examiner	events resulting in death) Last				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	d. UNPENDED AMENDED				
760, cate be physic the bur	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	•
Box 687 death certific he attending p	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy	Month	Day Year
Box e death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknown	Other (eposity)			
ires that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.			o the cause of death?
ds, I equires een sig				24a. Was an	24b. Were	autopsy findings available
e law requi e has been ge 2 should	Completed			autopsy performe 1 ✔ Yes 2	d? death?	
Vital Rec ysiciau: The his certificate director, page		25. Was case referred to medical	26.Place of Death (Check		NO IV	165 2 140
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other Nursi	ng Home 5 Re	sidence 6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requir as after cleah. In Director: After this certificate has been selod in by the funeral director, page 2 should I	on: T	27. Manner of Death 1 V Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year)	of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred	
isior Attend r death ector: by the	ertification:	2 Accident Investigation 28e Place of Injury - At home farm		28f. Location (Stre	eet and Number or F	Rural Route Number, City
Divising pital or At ours after derail Direct filled in by	ertif	3 Suicide 6 Could not be determined (Specify)		or Town, Stat	e)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciau: The law requires that the death certificate be executed within 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place, an tigation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as st d place, and due to	ated. the cause(s)
7. w. 7. 8	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (A	
		N_m_im	O.C.M.E.		October 20, 20	. <u></u>
\		Name and address of person who completed cause of death (item 23a) Donna M. Vincenti, MD	111 Penn Street, Baltimore, N	MD 21201		
\s	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
Regis	trar	OCT 22 2009 Cenus S. S.	aki			

ОНМН 17 Rev 1/2001 ОСМЕ 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Registrar 10/27/09, LDB

Certificate of Dooth

Certificate of Dooth Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NaoM. ackson October 009 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorc zenera Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Months Days Hours Director NOV. 1 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 0 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 $^{
ho}$ Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other that any lnjury or other traumatic event, the any lngury or other traumatic event, the once. ursing Assist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jackson nie Koberta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ambridge, MD, 21613 armkoad rystal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗹 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 10/28/09 Road 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A. Henry Funeral Ho 510 Washington St anbr. 194, MD. 21613 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one or line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** towners Oll /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ned by the a 9 Unknown cate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 🛣 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1 □ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2X ER/Outpatient 3 □ DOA nce 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident death. s after death 1 ☐ Yes 2 🗌 No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a

To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

P.O. Box 68760.

Records,

Division of Vital

			For State Registrar	State of M		Depa		t of H	ealth a			ene . 200	9	35816
	Physici /Medic	al	Decedent's Name (First, Middle, I Roy V. J Racility Name (If not institution, g	ones Sr.	r)		4h City	Town or	Location o	f Death	2. Date of Death Month 10	Day	Year 2009	3. Time of Death 8:00 P M
-	Examin	er	Dove House		nge (in yrs. last i	hirthday)		estn	inst	er	8 Date of Birth	(Carr	
	Funeral Director		212-14-9007 Usual Residence of Decedent	10XM 2□F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day,	Year) 1919	Cour	olace (State or Foreign htry) VA
	Maryland -f ehow	tor	10a. State 10b. County MD Carr	o11	10c. City, To		inste	er					1	0d. Inside City Limits 1X Yes 2 □ No
	th with the 23a or 28a	al Director	10e. Street and Number 73 Bond S	t.			10f. Zip	7				Og. Citizen of \		
920	within 72 hours after death with the Maryland ana. than "natural", or iteme 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates	s?] No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	city Yes or No- Rican, etc.)		ck, White,	ean Indian, etc. 7hite
Maryland 21215-0036	s I and 2 should be filad within 72 ho Haaith and Mental Hyglana. Item 27 ie marked other than "natur other traumatic event, the Medical	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education grade completed) College (1-40)	r 5+)	(Give life.	dent's Usua kind of wol DO NOT us hine	rk done d se retired,	u <i>ring</i> most)		ng	Smal: Manu	l To	ols
yland ;	2 should be filad within and Mental Hyglana. le marked other than aumatic event, ma Ma	To Be C	17. Father's Name (First, Middle, La James Josh	ua Jones					18. Mothe	rs Name 11a	(First, Middle, M	ia Hi	ne) rt	
Baltimore, Mar	4 O		19a. Informant's Name/Relationship Danny L. Jone 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe	S / SON	9 20b. Place ceme	8 E of Dispo	. Ma:	in S	St.,	Wes	tminst	er, MI	D 2	1157 own, State
Baltir	permit. Pag Dapartmant Important: I eny Injury o		21. Signature of Funeral Service Lice	L Sutta	Fr.	Li	2. Name an ttle	d Addres	s of Facilit	34	Maple	Ave 1		17340 lestown,P
8760,	Physician and wateriary (Medical Examiner thysician and the purial-transit	dical Examiner	23a. Parf1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause finite Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	is a consequent	00 of): 00 of): 00 of): 00 of):	ny	3						Interval Between Onset and Death
P.O. Box 68	that tha daeth cartificate ba ex ed by tha attanding physician detached for usa as tha burla	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death	ath 3[∃Ectopic pr ∃ Other (sp					I	te of delive	ery Day Year
rds, P.	w raquiras that baan signed by should be deta	d by Pr	Part II. Other significant conditions	contributing to death	but not resulting	g in the u	nderlying c	ause give	n in Part I.			acco use cont		he cause of death?
Reco	Tha law raqu ata has baan paga 2 shouk	Complete				-					24a. Was ar autops perform 1 🗆 Yes 2	ned?	prior to co death?	opsy findings available impletion of cause of
Division of Vital Records,	To the Hoepital or Attending Physician: Tha law raquiras that tha daath cartifica within 24 hours aflar daath. To the Funeral Director: Atler this cartificata has baan signed by tha attanding ph compiataly filled in by tha funeral director, paga 2 should be detached for usa as the	Certification; To Be	25. Was case referred to medical examiner? 1	be 28e. Placa of I	jury 28b Day Year) 28b njury - At home,	o. Time o Injury	f 2	8c. Injury Work 1 🗆 `	er: 4 □ Nu	rsing Hor		nce 6 DOtr w injury occur	red	N DOVE Ha WE
Ö	To the Hospital or Attendi within 24 hours aftar daath. To the Funeral Director: A complataly filled in by tha ft		29a. Certifier 1 Destifying	Physician: To the bes								use(s) and ma		
	fo the Ho vithin 24 I fo the Fu	Medical	(Check only 2 Medical Exone) 29b. Signatura and title of certifier	aminer: On the basis and manner:		and/or in			number	th occurr		ete and place,		
	WJL		30. Name and address of person wh		death (Item 23a	a) (Type,	Print)	0-0	052	1-21	8 1	0/22	100	3
	Sta	te	DR Raman 31. Date filed (Month, Day, Year)		strar's Signature	34	Ind	Colla	de	ine,	West	myy	עייו	21157
	Registr		OCT 23	2009 2	reine ,	Ø. 1	back							

			For State	State	of Marylan		artment o		nd Mental H	, 0		250	7
	_		Registrar 1. Decedent's Name (First, Middle	(a Last)		Cer	uncate c	Dealli	2. Date of D		2009	358	
	Physicia	an		corick l					Month	Da	ay Year		n M
	/Medic		JAIEM V 4a. Facility Name (If not institution		umbor)		4h City Town	n, or Location of			2, 2009 c. County of Dear	5:35 p	
	Examin	er	,		umber)		,			40			
46	Ermanal		Suburban 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	Bethesd	4 Hrs. 8 Date of B	irth	9. Bir	ntgomery thplace (State or For	eian
	Funeral Director		577-52-9653	1 X M 2□ F	73	Yrs.	Months Da	ys Hours	Min. (Month, L. July	Day, Year) Co	Cuba	Jigiri
			Usual Residence of Decedent		,,,				July .	11,	1930	Cuba	
2	/lanc		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Lin	nits
1	Mary Feb	to	Maryland Mo	ntgomery				Rockvil	10			Ma Yes 2□	No
	r 28e	Director	10e. Street and Number	negomery			10f. Zip Cod		16	10g. C	itizen of What Co	ountry?	
	3a o		1 Lorraine Cour	•+				20852			USA		
	Id be filed within 72 hours after death with the Maryland lental Hygiene. Ked other than "natural", or items 23a or 28a-f show ite event, it is Madical Eras or iter must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13. \	Vas Decedent		in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Ame	erican Indian,	
٥	or ite		1 ☐ Never Married 2 € Marr	ried Armed F	2 😿 No				Puerto Rican, etc.)		Black, White	e, etc.	
215-0036	al", c	5	3 Widowed 4 Divorced	If Yes, G Year or I	iive Dates:		I∐KYes 2∐I	No Specify:	Cuban		Specify:	White	
ק ק	72 ho	Completed	15. Deceden	t's Education	1		dent's Usual Oc		of working	16b. k	Kind of Business	Industry	
Z	thin 7	gu	Elementary/Secondary (0-12)	- ř – , – ,	(1-4or 5+)	life. L	DO NOT use rei	ne during most d ired)	or working				
7	d wil	ő	12				Types	etter			Newspap	er	
2	al H)	Be (17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (First, Middl	e, Maidei	n Surname)		
yland	uld b Ment rrkec	힏		Ping Kon	ricki				Cha	aja I	Lieberma	n	
Mar	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It et M		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	ig Address (Str	eet and Number	or Rural Route Num	ber, City	or Town, State,	Zip Code)	
Σ,	and Salth		Maria Koricki,	wife		1 Lo	rraine	Court,	Rockville	, Mai	ryland	20852	
<u>S</u>	of He		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other p	olace)	Date	20c. L	ocation - City or	Town, State	
Ĕ	Page nent int: If		12 Burial 2 □ Cremation 4 □ Dønation 5 □ Other (S		i State			, ,	0/25/2009	01ne	ey, Mary	land	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Si viature o Fun del Garvice	Licensee		22	. Name and Ad	dress of Facility	NERAL DIR				
ñ	Depar Impo any ir				MO125	5 E	DWARD S 091 Roc	AGEL FUI kville 1	NERAL DIRI Pike, Rocl	2011(cv i 1	JN, INC. le. Marv	land 208	52
			23a. Part 1. Enter the disease, or	complications that	caused the deat						ic, mary	Approximate Interval Between	11000
-	Physician	0	shock, or heart failure. List Immediate Cause (Final			1					3	Onset and Death	
1000	/Medical		disease or condition resulting in death)	ui.	iratory (oras a conseq		e				-	2-4 days	
	Examiner				estive H		odluro					/ 16 days	
,		e.	Sequentially list conditions, liarly, leading to innectate cause. Enter Underlying Cause (Disease or injury		(or as a conseq		arrure					4-16 days	
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Sepsi	is							7-16 days	
<u></u>	cate be executed physician and the burial-transit	Exa	resulting in death) Last	V	(or as a conseq	uence of):	·					, 10 days	
8/90,	te be /sicia e bur	dical		d.									
Q	tifical g phy as th	edi											
Š	andin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		-				23d. Date of de	livery	
Ď	death d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Preg	birth 2□Feta gnant at time of c] Ectopic pregna] Other <i>(specify</i>				Month	Day Year	
2	the sy the	hys	9 □ Unknown	9 □ Unk	nown								
,	s thai		Part II. Other significant condition	ns contributing to o	death but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	?
necords,	n sig	d by							1	Yes 2	2 □ No 3 □ P	robabiy 4 DUnkno	wn
္ပ	w rec	Completed							24a. Wa	s an	24h. Were au	topsy findings availa	thle
e E	he la e has ige 2	шd							— aut	opsy formed?	prior to death?	completion of cause	
N I I I	in: T ifficat or, pa	e C	25. Was case referred to medical					00 DI	1 ☐ Yes		o 1 □Yes	2 🗆 No	
>	sicia s cert irecte	ω	examiner? 1 Yes 2 No	Hospital	Inpatient 2	ED/Out-ation		Othor:	of Death (Check only		0 TO!!		
5	Phy er this	Ĕ	27. Manner of Death	28a. Date		28b. Time of	1 3 LI DOA	4 🗆 Nurs	sing Home 5 Res			city)	
	ding h. Afte	tio	1 Natural 5 Pendin	g (Moi	nth, Day, Year)	Injury		njuryat Vork? □Yes 2□No			.,		
VISION	Atten deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At ho	ome, farm, stre				(Street a	nd Number or Ri	ural Route Number,	
3	for / after Dire	Certification: To	4 ☐ Homicide determ	build build	ling, etc. '(Specif	fy)	, , ,		City or To	wn, Stat	re)	ara madio manipol,	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours aftered at the control of the thin 24 hours aftered and the control of the thing the thing the funeral director, page 2 should be detached for use as completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifyir	ıg Physician: To th	e best of mv kno	wledge, death	occurred at the	e time, date and	place, and due to th	e cause/	s) and manner a	s stated.	
	e Ho	Medical	(Check only 42 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, in n	ny opinion, death	occurred at the time	e, date ar	nd place, and due	to the cause(s)	
	of the	Me	29b. Signature and title of certific	20			29c. Lice	ense number		29d. Da	ate signed (Mont	h, Day, Year)	
	50		1 4 5	<.X			09	\$\$6816	60	10	122/09		
			30. Name and address of person	who completed com	ise of death (Item	n 23a) (Timo				-	,		
			Dr. Kimberly B.	•				d, Bethe	esda. Marv	land	20814		
	Stat	te	31. Date filed (Month, Day, Year)						,				
	Registra	-	OCT 26	2009	Registrar's Signa	B. Soa	well						

-08436		Please Type or Pr						ible.	
aron L. Leggett			laryland / Depa			a ivientai	Hygiene	0.0	00 0501
	F	- For State egistrar	Cer	tificate o	Death			. No.	49 3581
Physicia		1. Decedent's Name (First, Middle,Last)					2. Date of Death Month I October 31,	Day Year	0824 hrs
ledical Examir		Aaron Lynn	Leggett					4c. County of Dea	
		4a. Facility Name (if not institution, give stree	t and number)		4b. City, Town, or	Location of De	atn	Washington	ui
		20019 Lappans Road			Boonsboro	T	i lo Bata di Dinta	_	Sirthplace (State or Foreign
Funeral	- 1	5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Day		Min. Manage	13,1988 Ma	Country)
Director	- 1	$212-21-4054$ $_{1}X_{M}$	2 F 2	1 Yr			March	13,1988 Ma	aryland
		Usual Residence of Decedent							10d. Inside City Limits
, any	- 1	10a. State 10b. County		Town or Loca					1 Yes 2 X No
and show nce.	5	Maryland Washington	Во	onsbor)				
faryl:	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
the A a or	히	20019 Lappans Road			21713			U.S.A.	
with	uneral		Was Decedent Ever in U.		as Decedent of Hi		(Specify Yes or No-	14. Race - Am White, etc.	erican Indian, Black,
Jeath r iter	Ĭ	1 X Never Married 2 Married 1	Armed Forces? Yes 2 X No	310			sito rioan, cic.,	TVIII.O, Old	1
after al", o	by F	3 Widowed 4 Divorced If Yes, or Da	Give Year	1				Specify:	White
ours atura	g p	15. Decedent's Education (Specify only high	nest grade completed)		nt's Usual Occupa			16b. Kind of Busines	s/Industry
72 h	ete	3, ,	ollege (1-4 or 5+)		·		,	0	•
5-0036 led within 72 hours after tygiene. other than "natural",	Completed	12		Elect	rician			Contract	ing
5-0036 iled within 7 Hygiene.		17. Father's Name (First, Middle, Last)					ame (First, Middle, M		
21 be fi ental rrked		Jeffrey Lynn Leggett		-			a Ginette		rte Zie Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, F		7.1			or Rural Route Numl		
timore, MD 2 t. Pages I and 2 shou treent of Health and I reant: If item 27 is n		Jeffrey L. Leggett /			L9 Lappa		BOONS DO:	ro, Mary Lary La	and 21713
Fe, and file		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re		crematory or o	ther place)	emetery,	Date	200. Education - Oily	or rown, outo
Page lent o		4 Donation 5 Other Specify:			o Cemete				o, Maryland
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Funeral Service Licensee	17						al Home, P.A.
E. E & W	i	Xacypia	Kal	7	606 Old	Nationa	1 Pike B	oonsboro,	
Physician		23a. Part I. Enter the disease, of complication failure. List only one cause on each line	ns that caused the death	. Do not enter	the mode of dying	g, such as cardi	ac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Ca	rdiomegaly	with 1	eft vent	ricular	hypertro	phy	Death
xaminer		or condition resulting in death) Due to	(or as a consequence of	f): and b	iventri	cular d	ilatation		
	.	Sequentially list conditions, b							
	miner	cause Enter Underlying Cause	o (or as a consequence of	f):					
	E	(Disease or injury that initiated C.	o (or as a consequence o	f):					
e executed itan and ital - transit	Exa	d.							
executed an and al - trans	lical	X UNPENDED AM	ENDED 3a, 27, pe	· rmF	207 11/	23/09 11"	T		
tox 68760, eath certificate be attending physicil for use as the buri	Jed		L If yes, outcome of preg	nancy	3097 1174	23/07 1	1	23d. Date of deli	very
187 tifica ing pl as th	cian/Med	23b. Was decedent pregnant in the past 12 months?	Live birth	2 F	etal death 3	Ectopic pr	egnancy	Month	Day Year
th cer	ici	4	Pregnant at time of de	eath 5	Other (Specify)			ŀ	
Bo) te deat the att	Physi		Unknown			ive- in Death	Lago Did to	bacco use contribute	e to the cause of death?
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physic page 2 should be detached for use as the bur	by P	Part II. Other significant conditions cont	ributing to death but not r	esulting in the	underlying cause	e given in Pan i.			Probably 4 Vunknown
ires t	d b								
ords w requi	Completed						24a. Was autop	sy prior	e autopsy findings available to completion of cause of
e law te has ge 2 sl	m						perfor	med? deat	
tal Rectan: The certificate ector, page		25. Was case referred to medical			26.Pla	ice of Death (Ch			
Vital hysician:	Be	examiner? Hospit	al: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	Other N	lursing Home 5	Residence 6 🗸 C	ther: Scene
of V ing Phy After th Tuneral	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time o	f Injury 28c. Ir	njury at Work?	28d. Describe	now injury occurred	
ion of tending Pheath.	io	1 X Natural 5 Pending	(Month, Day,Year)		1	Yes 2 No	0		
Sicolo Atter	cat	2 Accident Investigation	28e. Place of Injury - At h	ome, farm, st	reet, factory, office	e building, etc.	28f. Location (S	Street and Number o	r Rural Route Number, City
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been seempletely filled in by the funeral director, page 2 should!	Certification:	Suicide Could not be determined	(Specify)		-		or Town, S	State)	
lospit hour unera ly fill		4 Homicide 29a. Certifier Check only 1 Certifying Physician: 1		ige death occ	curred at the time	date and place	and due to the caus	se(s) and manner as	stated.
To the Hos within 24 h To the Fun completely	lica	one) 2 Medical Examiner: On t	he basis of examination	and/or investig	gation, in my opini	ion, death occur	rred at the time, date	and place, and due	to the cause(s)
To with To com	Medical	29b. Signature and title of certifier	manner stated.			ense number		29d. Date signed	
		Quit?			0.0	C.M.E.		November 1,	2009
		west		230)					
٥١١		30. Name and address of person who comp Ana Rubio MD Assistant M			Street. Baltir	more, MD 2	1201		

State Registrar 31. Date filed (Month, Pay Year) 2 2009

park

OCME

		For State Registrar	State	of Marylan		artment of H			giene Reg. No. 2 (009	35	819
Discontinuit		1. Decedent's Name (First, Middle			_			2. Date of De Month	Day	Year	3. Time of	
Physicia /Medic	al			NGLEY			I I Day	NOV.	2 20 4c. County		5:30	p "'
Examin	er	4a. Facility Name (If not institution 320 Southeas	n, give street and n st Creek	umber) Rd -		4b. City, Town, or Church		atn	1		nne's	
		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hi	rs. 8. Date of Bir			lace (State o	r Foreign
Funeral Director		219-16-5552	¥ □ M 2□ F	83	Yrs.	Months Days	Hours Mi	n. 8. Date of Bir (Month, Da July	29 192	6 Ma	rylan	d
P.		Usual Residence of Decedent		100 Cit	y, Town or Lo	eation				1	0d. Inside Cit	y Limits
arylaı shov	'n	10a. State 10b. County			,						1 ☐ Yes	2 No
the M 28a-f	ect	MD Ques	en Anne'	s Cn	urch	10f. Zip Code			10g. Citizen of	What Cour	ntry?	
with sa or	I Di	320 Southeas	st Creek	Rd.		21623			U.S.A	•		
death ms 2;	Funeral Director	11. Marital Status		cedent Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? n. Mexican, Pu	(Specify Yes or No erto Rican, etc.)	14. Ra	ce - Americ		
or ite		1 Never Married 2 Mar	ied 1X Yes	2 □ No 19	44	1 □Yes 2 📉 No				y: Wh:	ite	
ural",	d by	3 ☐ Widowed 4 ☑ Divorced	Year or			dent's Usual Occup	ation		16b. Kind of B	Business/In	dustry	-
in 72	Completed	15. Deceder (Specify only highe			(Give	kind of work done of DO NOT use retired	during most of w	vorking				
I withi giene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)	Pres	ident			Propa		ompan	У
be filed within 72 hours after death with the Maryland tal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, it a Medical Exeminar must be notified at	Be C	17. Father's Name (First, Middle,						lame (First, Middle		me)		
lal ylallo 6.16. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ita M	2	Francis Nort		igrey	T			ie Kend		Ctata Zir	Cada) 2	0.600
/ I and h and / Is m rraum		19a. Informant's Name/Relations Donald E. La		(con)	1	ng Address (Street						0622 . MD.
Te, Mal yid s 1 and 2 should of Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	ingrey			osition (Name of matory or other place		Date	20c. Location			1112
Pages nent of lint: If ite		1 Burial 2 Cremation 4 Donation 5 Dother (5				matory or other place emation	e) ; 11.	/3/09	Smyrn	a, Di	Е.	
그 원원들 .	1	21. Signature of Fune al Service			2	2. Name and Addre alena Fi	ss of Facility	Ното о	f Ston	hon	r. Sch	aach
Depa Depa Impo any is		H	X	M005	10 1	18 West	Cross	St. Ga	lena. i	MD.	21635	
		23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause or	t caused the deat	th. Do not en	ter the ode of dyir	ng, such as card	diac or respiratory	arrest,		Approximat Interval Bet Onset and	e ween Death
Physician	Ď.	Immediate Cause (Final disease or condition	_ a.	Weller	loter	Melo	nune	٧				
/Medical Examiner		resulting in death)	Due	o (or as a consec	quence of):							
	ē.	Sequentially list conditions,	b. — Due t	o (or se a consec	uence of							
uted d ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5									
be executed ician and burial-transit		resulting in death) Last	Due	o (or as a consec	quence of):							
e y e	ical		d									
The Cords, F.O. BOX 60 The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	000 11		2000				nod D	ate of deliv	1071	
DOX sath cer attendin for use	jan/	23b. Was decedent pregnant in the past 12 months?	1 🗀 Liv	outcome of pregn re birth 2 Fet eanant at time of	al death 3	☐ Ectopic pregnand	;y			ate of deliv Month		Year
the de	ysic	1 □Yes 2 □No 9 □ Unknown		known	dedii 5							
that the hold by detail		Part II. Other significant condit	ions contributing to	death but not re	sulting in the I	underlying cause giv	en in Part I.	23e. Did	tobacco use co			
Hecords ne law requires s has been sign ge 2 should be	od by							_ 1□	Yes 2 No	3 ☐ Pro	bably 4 🗆	Unknown
aw re-	plete							24a. Wa	ppsv	. Were aut	opsy findings	available cause of
The I	Completed							per 1 □ Yes	formed? 2 No	death? 1 □ Yes	2 110	
VITAI Ician: T certificat ector, pa	Be	25. Was case referred to medical examiner?	I I a a mid a la			0#	OF:	Death (Check only				
hys his ldir	은	1 Yes 2 No		Inpatient 2	ER/Outpatie	ant 3 LI DOA	ner: 4 🗆 Nursir		sidence 6 C		cify)	
dlng I	ion	27. Manner of Death 1 Natural 5 Pendi	/8/	lonth, Day, Year)	Injury	Wo	k?]Yes 2 □ No	200. 2000/100	, non ngary see			
VISION r Attending er death. rector: Afte	fical	3 ☐ Suicide 6 ☐ Could	not be 28e, Pla	ace of Injury - At I	nome, farm, s	treet, factory, office			(Street and Nur	nber or Ru	ral Route Nui	nber,
al or /	Certification:	4 Homicide	bu bu	ilding, etc. '(Spec	iny)			City Of 10	Jwn, State)			
To the Hospital or Attending P virthin 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical (29a. Certifier 1 Certify (Check only one) 2 Medica	I Examiner: On th	the best of my kr e basis of examin namer stated.	nowledge, dea nation and/or	ath occurred at the t investigation, in my	ime, date and p opinion, death o	place, and due to the control occurred at the time	ne cause(s) and e, date and place	manner as e, and due	stated. to the cause	(s)
the ithin 2 the orthe	Med	29b. Signature and title of certif	A 0	stated.		29c. Licen	se number		29d. Date sign	ned (Month	n, Day, Year)	
E 3 F 8		1/1/w	red 4			10	0060	0301	11	310	9	
		30. Name and address of perso Michael E.	n who completed o	ause of death (ite	em 23a) (Type				n MD	216	20	
St	ate	31. Date filed (Month, Day, Yea		2. Rigistrar's Sign		books!	A. CITE	S COL COW	i, FID.	210	۷	
Regist	rar	PE 17 2	. 61	1	1	7						

State of Maryland / Department of Health and Mental Hygiene 2009

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Physic /Med Exami

For

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Mudical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

C

Division of Vital Records, P.O. Box 68760,

P	2	
	Sta Registi	

	7 - State Registrar		Certificate of Death				Reg. No.			
	1. Decedent's Name (First, Middle, Last)		2. Date of Deat				_	Voor	3. Time of Death	
	Clara C. Lavorata		Oc ^{Month} er					$2\overset{\text{pay}}{2}$, $200\overset{\text{year}}{9}$ 2:3.		
	4a. Facility Name (If not institution, give street and number)	4b. Cit	y, Town, or Loc	ation of Death		4c. 0	County of Dea	th	
	Shady Grove Nursing and Re	hab	Roc	kville			Mo	ntgome	CY	
7		ge (In yrs. last birtl			Jnder 24 Hrs.	8. Date of Bir	th	9. Bir	thplace (State or Foreig	
	578-42-2047 1□ M 250xF	87 Y	rs. Month	s Days H	ours Min.	June 17	1922	Wes	ountry) t Virginia	
	Usual Residence of Decedent									
	10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits	
	Maryland Montgomery	Rockvi	11e						1 ∐Yes 2 x∏x No	
	10e. Street and Number			ip Code			10a. Citiz	en of What Co	untry?	
	9701 Medical Center Drive		1.5	20850			_	SA	,	
			10.11							
	11. Marital Status 12. Was Decedent Armed Forces)	If Yes, sp	edent of Hispar ecify Cuban, M	exican, Puerto	ecify Yes or No Rican, etc.)	1	 Race - Ame Black, Whit 		
٠,	Never Married 2 Married 1 Yes 2 If Yes, Give	·No	1 □Yes	2 No Sp	pecify:			Specify: W	hite	
	3 ☐ Widowed 4 ☐ Divorced Year or Dates:							,		
	15. Decedent's Education (Specify only highest grade completed)		(Give kind of w	ual Occupation ork done during	g most of work	ing		d of Business	ŕ	
١	Elementary/Secondary (0-12) College (1-4or	5+)	life. DO NOT	use retired)			Not.	Applicat	ole	
	10	D.	isabled							
	17. Father's Name (First, Middle, Last)					e (First, Middle				
	Frank Lavorata Sr.			(atherine	C. Cio	carel	To		
	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Addre	ss (Street and I	Number or Run	al Route Numb	er, City or	Town, State,	Zip Code)	
1	Frank Lavorata / Brother	76	613 Eps	ilon Driv	e Rockvi	lle, Mary	and	20855	,	
-	20a. Method of Disposition	20b. Place of I				Date		ation - City or	Town, State	
	1 Burial 2 □ Cremation 3 □ Removal from State	I			10/29	/2009	Suitland, Maryland			
	4 ☐ Donation 5 ☐ Other (Specify)	Cedar II	ill Ceme							
	21. Signature of Lineral Service Licensee			and Address of	Ge				eral Home,	
j	Man Meer					Oxon H		MD 207	745	
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do no ine.	ot enter the m	ode of dying, su	ich as cardiac	or respiratory a	rrest,		Approximate Interval Between	
1	Immediate Cause (Final DEMENTET A							1	Onset and Death 6 months	
	disease or condition resulting in death) Due to (or as a consequence of):								O IIIOIIGIS	
	Due to (or as a consequence or).									
	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of	f):							
1	cause. Enter Underlying Cause (Disease or Injury									
1	that initiated events c.	a consequence of	of):							
								·		
	d									
1	IF FEMALE;									
		2 Fetal death	3 🗆 Ectopic				2:	3d. Date of de Month	livery Day Year	
	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant	at time of death	5 Other (specify)				WOUTE	Day Teal	
1	9 LI Unkhown									
- 1	Part II. Other significant conditions contributing to death	out not resulting in	the underlying	cause given in	Part I.	23e. Did t	obacco us	e contribute to	o the cause of death?	
	HYPERTENSION					1 🗆 '	Yes 2🛚	′es 2∭X No 3 ☐ Probably 4 ☐ Unknow		
			240 Mea a					utopsy findings available		
	PARKINSON'S DISEASE					24a, Was	an I	by prior to completion of cause		
	PARKINSON'S DISEASE		TCEAC			auto	osy			
	CHRONIC OBSTRUCTIVE		ISEAS			auto perfo 1 🗆 Yes	osy rmed? 2 XIM o	death?	2 □ No	
	CHRONIC OBSTRUCTIVE 25. Was case referred to medical examiner?	LUNG D		26.		auto perfo 1 □ Yes n <i>(Check only o</i>	osy rmed? 2 X 1 X 0 one)	death? 1 □ Yes	s 2□No	
	CHRONIC OBSTRUCTIVE 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpat	LUNG D	patient 3 ☐ [26. OOA Other: 4	Nursing Ho	autoj perfo 1 □Yes n <i>(Check only c</i> me 5 □ Resi	osy rmed? 2 X) M o one) dence 6	death? 1 Yes	s 2□No	
	CHRONIC OBSTRUCTIVE 25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpat 27. Manner of Death 28a. Date of Inj	LUNG D	patient 3 [26. OOA Other: 4 28c. Injury at Work?	Nursing Ho	auto perfo 1 □ Yes n <i>(Check only o</i>	osy rmed? 2 X) M o one) dence 6	death? 1 Yes	s 2□No	
	CHRONIC OBSTRUCTIVE 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpat 27. Manner of Death Manual 5 Pending investigation 28a. Date of Inj (Month, Di	LUNG D	patient 3 🗆 [26. OOA Other: 4	Nursing Ho	autoj perfo 1 □Yes n <i>(Check only c</i> me 5 □ Resi	osy rmed? 2 X) M o one) dence 6	death? 1 Yes	s 2□No	
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			1- For Amend Items 283 af Maryland Department 1997, 11/00/09011.	ggjabey	giene Reg. No. 2 (109	35821
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De		Year	3. Time of Death
	/Medic			OCTOBE		09	8:50 A M
3	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County		
	Funeral		FREDERICK MEMORIAI, HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Bird	FREDE		ace (State or Foreign
	Director		181-05-1664 1 M 2 F 94 Yrs. Months Days Hours Min.	8. Date of Bird (Month, Da 10-29-	y, Year) 1914	Count	PA
	pr ,		Usual Residence of Decedent				
	shov	ក	10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	the M 28a-f	ect	MD Frederick Frederick 10e. Street and Number 10f. Zip Code		10 02:	10	1 ☐ Yes 2 🔼 No
	Mith Ba or	ij	8222 Glen Heather Drive 10f. Zip Code 21702		10g. Citizen of \	wnat Counti	·y?
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examitant must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No	USA 14. Rad	e - America	n Indian,
9	or Ite	/ Fu	Armed Forces? 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ▼ No	Rican, etc.)	Blac	ck, White, et	c.
003	ural",	d b	3 ☑ Widowed 4 □ Divorced Year or Dates:		Specify	"Whit	e
21215-0036	n 72 ł	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workir life. DO NOT use retired)	ng	16b. Kind of Bi	usiness/Indu	ıstry
212	within jiene. r than "	omp	Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker		Own Ho	nmo	
	al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,			
Vlai	should be and Mental marked c	70 E	Harry Smeigh Eva Eliz	abeth S	Solomon		
lar	2 sho n and Is ma rauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura				*
e,	l and lealth sm 27 ther tu		Dee Ann Weller Daughter 8222 Glen Heather Drive				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Michael Examilism mast be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cematery, crematory or other place)	ate	20c. Location -		,
Ħ	nit. Partme artme ortant Injury				Frederi		
Ba	permit. P Departme Importan any Injur once.		21. Signature of Puneral Service License MO1176 22. Name and Address of FacilityKeen MO1176 106 East Church Str	iey & Ba eet Fre	astord E ederick.	AF. MD2	H. 1 ∕701
			23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shoet, or heart failure. List only one cause on each line.			N. V.	Approximate nterval Between
4	Physician		Immediate Cause (Final disease or condition		000		Onset and Death
J	/Medical Examiner		resulting in death) Due to (or as a conseq, ence of):	9)	TON	h, 9	7
P		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ento	1/2/	f	2 day
8	uted d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury	1 PT W	2 W		0
o î	exec an and rial-tra	Еха	that initiated events c	1 1	KD.		
68760,	ificate be executed physician and the burial-transit	edical	d	2010x	V.		
		Med	IF FEMALE:	> pic			
Вох	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			te of deliver	y Pay Year
o	I he law requires that the death ate has been signed by the atter age 2 should be detached for u	ysic	1 ☐ Yes O☐No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		1010		real
σ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
rds,	quires n sign ald be	d by	Hayace tynios	1 □ Y	es 2 No	3 ☐ Proba	bly 4 ☐ Unknown
Vital Record	law rec as bee 2 shou	Completed	Att al theil tide	24a. Was a	an 24b. \	Nere autops	sy findings available
		E O		autop perfor	med? [prior to compleath?	pletion of cause of
ita	sician: The la certificate ha irector, page 2	Bec	25. Was case referred to medical examiner? 26. Place of Death			I∐Yes 2	LINO
> ·	hysic this ce	၉	Yes 2 No Hospital: 4 Nursing Hom	ne 5 ☐ Resid	lence 6 Oth	er (Specify)	
ב ב	After i	ö	1 Natural 5 Pending (Month, Day, Year) Injury Work?		ow injury occurr		
Division of	death ctor: / the	cat	a Toutette C T Could not be	•			wheelchair
<u>}</u>	after Direction by	Certification:	determined determined determined determined determined determined determined building, etc. (Specify) Assisted Living Facility	City or Tow	n, State) 822	Glen	Route Number, Heather
	ospita hours ineral y fille		29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place a	and due to the	Frederic	nner as sta	ted
-	or en cospiral or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, g	edical	(Check only one) 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time,	date and place,	and due to t	he cause(s)
i	Vith vith com	Σ	29b. Signature and title of certifier 29c. License number	2	29d. Date signed	(Month, D	ay, Year)
			My Chy D16428		10	28	09
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	01704	1	1	
	Stat	e_	Casper E. Cline III 300 West 9th Street Frederick, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature.	Z1/01			
	Registra		MOVING 2000 A A March				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 31, **Physician** Margaret Jennie Magnus 2009 8:55 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 8. Date of Birth (Month, Day, Nov. 5, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 3/5/F Days Hours Min. 215-26-8021 79 1929 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It will all Exploit at must be nedified at any once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Frederick Middletown 1 ☐ Yes 2 XNo **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6209 Paul Rudy Road 21769 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed/Baker Bakery/Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Emory Ropp Naomi Ruth Masser ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6209 Paul Rudy Road, Middletown, MD 21769 Gayla R. Magnus, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Nov. 5, 2009 Smithsburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune at Service 22. Name and Address of Facility. Keeney and Bastord PA_Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \subseteq Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part Il Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ≥No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page Medical Certification: To 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature dittle of certifier 0006223 November 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIVE, FREDERICE, MD - 2/702 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 6 2009 parcel Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Aileen Murrell Jessie October 21, 200^yg^{ar} 8:20P. M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Arcola Health and Rehabilitation Ctr Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 27, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1924 1 □ M 2√2 F Tennessee 412-36-2416 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wediest Exa, when must be notified at once. 10a. State 10b. County Silver Spring Maryland Montgomery 1 ☐ Yes 2 TNO Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1004 Noves Drive 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: White þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Allen A. Holt Lavalla Akin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Frick -daughter 1004 Noyes Drive Silver Spring, Maryland 20910 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 10/24/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Poneral Service Licensee Bonard V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriah-transit Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure to Thrive; Dementia; Recurrent Sepsis; 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Clostridium 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy 2 X No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signatury and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Division of Vital Records,

Baltimore, Maryland 21215-0036

P.O. Box 68760.

State Registrar Shyamsundar Rajan, M.D. 9801 Georgia Avenue, #117 Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) Registrar's Signature 26 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D53367

October 22, 2009

		•		epartment of Health and Certificate of Death	Mental Hygier Reg.		35821
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Martha C. Milton		2. Date of Death Month October 21,	Day 2009 Year	3. Time of Death 8:05 P M
تمريب	Examin		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Deat Clinton	h	4c. County of Death Prince Ge	orge's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho			9. Birth West	olace (State or Foreign
	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Decedent Montal and Decident				0d. Inside City Limits
	the Ma a or 28a be notif	Funeral Director	10e. Street and Number	ashington 10f. Zip Code	10g.	Citizen of What Cou	1 Yes 2XX No
	ems 23	unera	4401 Summit Place 11. Marital Status 12. Was Decedent Ever in U.S.	20744 13. Was Decedent of Hispanic Origin? (S)	pecify Yes or No-	USA 14. Race - Americ	an Indian
920	rs after de ural", or its Examine	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZHX No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify:	o Rican, etc.)	Black, White,	
yiang 21215-0036	iin /2 hou ie. han "nati e Medica	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)		. Kind of Business In	dustry
7 0	Hygien Other t	Be	4 years Sch 17. Father's Name (First, Middle, Last)	ool Teacher	me (First, Middle, Maid	ducation	
yian	nd be no no no no no no no no no no no no no	To	Gentle L. Marshall	Edie	L. Fel	ious	
Ξ Ξ	d 2 shol alth and 1 27 is n	1	[]	Mailing Address (Street and Number or Ru 01 Summit Place Ft.			Code) 744
baltimore,	permit. Fage i and 2 should be filed within /2 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Innportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition 20b, Place of D	Disposition (Name of crematory or other place)	Date 20c	Location - City or To	
Dail	Departr Departr Import any inji		21. Signature of Funeral Service Licensee	22. Name and Address of Facility G 6160 Oxon Hill Road O	eorge P. Kala xon Hill, Mar	s Funeral Ho yland 2074	
P	h, sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	A	or respiratory arrest,		Approximate Interval Between Onset and Death
}	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence f)				
۰		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of)	15			
7 OU	an and rial-trans	edical Examiner	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of)			1	
			d		-		
DOX GO	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
	igned by		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to th	
ecorus,	s been s	Completed by	DEMENTIA DISSEMINATED INTRAVASCULAR	COAGULATION	24a. Was an	24b. Were auto	pably 4 Unknown psy findings available
	ficate has				performed		mpletion of cause of 2 No
VICAL	is certii	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death (Chematient 3 DCA Other: 4 Nursing H	ck only one) Iome 5 Residence	6 ☐ Other (Specify)
IVISION OF	eath. or: After the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injury (Month, Day, Year)	28d. Describe how in	Describe how injury occurred		
	ins after de al Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and City or Town, Sta		Route Number,
the Hoen	hin 24 hou the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de only one) 2 Medical Examiner: On the basis of examination and/or in the best of my knowledge, de only one)	nvestigation, in my opinion, death occurred	at the time, date and pla	ice, and due to the car	use(s) and manner stated.
þ	70 with		29b. Signature and title of certifier	29c. Eisense number 5 3 8 8 5		Date signed (Month, I	pay, Year) 2009
R	-6			14775 (4074) #	307 Cun	ron Ms	20735
	Stat Registra		31. Date filed (Month, Day, Year) OCT 2 6 2009 Server 32. Registrar's Signiture				

1. Decedent's Name (First, Middle, Last) LESTER WILLIAM METZINGER Certificate of Death

2. Date of Death SEPTEMBER 27, Year 2009

06:23P.M

9. Birthplace (State or Foreign

WASHINGTON, DC

10d. Inside City Limits

1 ☐ Yes 2 No

Approximate
Interval Between
Onset and Death

Hmmths

Year

4a. Facility Name (If not institution, give street and number)

MANDRIN CHESAPEAKE HOSPICE HOUSE

4b. City, Town, or Location of Death

HARWOOD

4c. County of Death

UNITED STATES

14. Race - American Indian Black, White, etc.

Specify: WHITE

ANNE ARUNDEL

Funeral

Director

ns 23a or 28a-f show Funeral Director ō Completed by Be

should be filed within 72 hours after death with the Maryland ulth and Mental Hygier
27 is marked other the
r traumatic event, man permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any Injury or other traun

ဂ

Examine

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner burial-trar Hospital or Attending Physician: The law requires that the death certificate be execu death. nours after death neral Director: / filled in by the f

To the Hospital within 24 hours a To the Funeral 124

Division of Vital Records, P.O. Box 68760,

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Days Months Hours 1 ▼ M 2 □ F MAY 10, 1923 86 579-18-2739 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2642 COMPASS DRIVE 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates: ²□No 1942-1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR BUREAU OF ENGRAVING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LESTER HARRY METZINGER MARGARET MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NITA MARIE METZINGER/WIFE 2642 COMPASS DRIVE, ANNAPOLIS, MARYLAND 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of ARLINGTON NATIONAL CEMETERY OCTOBER 1 ■ Burial 2 □ Cremation 3 □ Removal from State 2009 ARLINGTON, VIRGINIA
22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM
CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE
ROAD, ANNAPOLIS, MARYLAND 21401 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metactatic undifferentiated smell cell lung disease or condition resulting in death) Due to (or as a consequence of): hranic Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) OSTEOPOROSIS Due to (or as a consequence of): Peripheral Vascular

Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Completed

3 Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown

23d. Date of delivery

Day

Month

Cance

25. Was case referred to medical examiner?

24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) HOSTICE Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 Suicide 4 Homicide

1 Yes 2 No

29a, Certifier

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number D3199

JE100

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003 Medical Phoy HNDREW GORDON

State Registrar 31. Date filed (Month, Day, Year) SEP 3 0 2009

Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

State of Maryland / Department of Health and Mental Hygiene 2000

		•	For State Registrar		, , , , , , , , , , , , , , , , , , ,	Ce	rtificate of	Death		Re	g. No.	009	3302
	Physicia	ın	1. Decedent's Name (First, Midd		N					Date of Death Month	Day	Year	3. Time of Death 5:20 pm
	/Medic		7		New					Octobe	_	2009	3.20 pm
	Examin	er	4a. Facility Name (If not institution Manor Care		er)		4b. City, Town, o	or Location of Bethesd			1	y of Death Ontgom	10 H II
	Funeral		5. Social Security Number		Age (In yrs. la	st birthday)	If Under 1 Year			Date of Birth Month, Day,		9. Birthp	lace (State or Foreign
	Funeral Director		145-28-4337 Usual Residence of Decedent	1□M 2ÅF	72	Yrs.	Months Days	Hours	Min. Ma	Month, Day,	1937	West	Virginia
	land ow	- 1	10a. State 10b. Count	у	10c. City,	Town or Lo	ocation					1	0d. Inside City Limits
	Mary Fe sh	ţċ	DC				was	hingto	n				1 X ∏Yes 2 ☐ No
	with the Maryland a or 28a-f show be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Coun	itry?
	23a c	al	1 Scott Circ	le, #810, N	W			20036	,			u.s.	Α.
	r dea	nue	11. Marital Status	12. Was Decede Armed Force	es?	. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		ace - Americack, White, e	
Maryland 21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show digal Everinee must be notified at	β	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	_		1∐Yes 2⊠No	Specify:			Speci	ify:	White
5-(72 hours "natural"; dical Exe	lete	15. Decede (Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occu kind of work done	during most of	of working	1	6b. Kind of E	Business/ind	dustry
121	vithin sne. than '	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use retire Bookkee	,			Ra	eal Es	tato
d 2	al Hygie other	ပ္	17. Father's Name (First, Middle). Last)			DOUGLEE	*	's Name (Fi	rst, Middle, M			
an	ould be f Mental arked o atic eve	To Be	Unknown	/				Unkno	iwn.				
Z.	2 should be and Mental ls marked or raumatic ev	Ě	19a. Informant's Name/Relation	ship (Type. Print)		19b. Maili	ng Address (Stree	1		oute Number,	City or Town	n, State, Zip	Code)
ž	s 1 and 2 should be filed within 7? f Health and Mental Hygiene. item 27 Is marked other than "n other traumatic event, the Modi		Barty D. New -	Spouse		1 Sc	ott Circl	Le, #81	O, NW	, Wash	ingtor	ı, DC	20036
ore,	ss 1 and 2 of Health Fitem 27 r other tr		20a. Method of Disposition		20b. Pla	ace of Disponetery, cre	osition (Name of matory or other pla	ice)	Date	2	Oc. Location	- City or To	wn, State
<u>E</u>	Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (are i	Linco	oln Crema	tory	10/29	12009 1	Brentu	ood,	Maryland
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service	Licensee M	00709		2. Name and Addr 040 Rocki						CCremation 1852
			23a. Part f. Enter the disease, shock, or heart fature. Li	or complications that cau	sed the death.	Do not en	ter the mode of dy	ing, such as c	cardiac or re	spiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					1.00	4000	1			Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseque	nce of):	TO IAL		THE I	0 N			Z (170)
	Examiner		Sequentially list conditions, if any leading to immediate b. CIRBRAVABULAR ACCIDENTS Due to (or as a consequence of):										YEAR
0	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):					•		
D	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	as a conseque	ence of):							
9	be cia					,							
68760	rtificate ng phys as the	Medical		d						_			
Вох	requires that the death certificate een signed by the attending physi rould be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75-4				23d. D	ate of delive	ery
	death	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No		th 2 Fetal ont at time of de		☐ Ectopic pregnar ☐ Other <i>(sp</i> ec <i>ify)</i>				V	/lonth	Day Year
P.0	n requires that the diben signed by the should be detached	hys	9 Unknown				_						
	es thi	by	Part II. Other significant condi	tions contributing to deat	th but not resul	ting in the u	inderlying cause g	ven in Part I.					he cause of death?
ord	een s ould								—	1 ∐ Ye	s 2 No	3 □ Prot	oably 4 🔀 Unknown
lec	2 38	Completed								24a. Was an autopsy	/	prior to co	ppsy findings available mpletion of cause of
F	The gate	S								perform 1 □ Yes 2	No No	death? 1 ☐ Yes	2 □No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:						heck only one			
of	ding Physician: ۱. After this certific funeral director,	٠ <u>.</u>	1 Yes 2√No 27. Manner of Death	1 L Inp	niury :	R/Outpatie	III 3 DOA	4,23,1911		5 Reside			fy)
Division of Vital Records,	ding F. h. After funera	tion	1 Natural 5 ☐ Pend	ing 28a. Date of (Month, tigation	Day, Year)	Injury	We	ork? ∐Yes 2 □ N		Describe no	iv injury occu	incu	
İSİ	Atten deat ctor: y the	fica	3 Suicide 6 Coul		Injury - At hon	ne, farm, st	reet, factory, office		28f.	Location (Str	reet and Nun	nber or Rura	al Route Number,
Ö	al or a s after I Dire	Certification: To	4 ☐ Homicide deter	building	, etc. (Specify))				City or Town	, State)		
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical (ring Physician: To the beat Examiner: On the bas	is of examinati								
	Fo the within Fo the complex c	Me	29b. Signature and title of certif				29c. Licer	nse number		29	9d. Date sign	ned (Month,	Day, Year)
	5		M-S-	noyo			Ī	0-178	374		10.	22 -	2009
)		30. Name and address of person	n who completed cause	of death (Item	23a) (Type	Print)						
			S-M-NAYA	R ND	37	17	38 14 A	VE B	BREW	Twat) ~	y 20	722
	Sta Registr		31. Date filed (Month, Day, Yea OCT 26	2009 Centre	gistrar's Signatu	Je face	Ked.						
						-							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 18, 2009 **Physician** Marjorie Lavina Nagle /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 2841 Snydersburg Road Carroll County Hampstead If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 K F 92 213-18-8059 1917 Maryland **Director** Apr. 14. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Exercites in ust be notified at Maryland Carroll County Hampstead 1 ☐Yes 2 XNo Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" — any injury or other traumatic events. 2841 Snydersburg Road 21074 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2XNo Specify: white Specify: ð 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) retail sales store owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe C. Simmons Estie V. Harris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. Neudecker - daughter 2841 Snydersburg Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mark's Church of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22, Hampstead, Maryland Snydersburg Cemetery 2009 22. Name and Address of Facility 21. Signature of Funeral Service Lice Funeral Home Hampstead, Maryland 21074 Eline 934 South Main Street M01072 Turn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dreumonia **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ demention VASCULAR 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSIVE carpiovascular DISEASE 24a. Was an autopsy performed 2 No 1 □Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Phesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗺 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 2 29d. Date signed (Month. Dav. Year)

State

NI

29b. Signature

and title of certifier

Deogracias V. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

austino,

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

29c. License number

HAMPS tead

M.D; 4111 Laver Beckleys ville Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

8

			- For State		Certific	cate of	Death			Reg.	No.	200		<u>358</u> 2
F Nedical	Physicia Exami	ın/	1. Decedent's Name (First, Midd KAREN	PATRICI	E	0'	NEAL		2. E N O	Date of Death Month D October 22,	ay Year 2009		Time of De 0519 hr	
			4a. Facility Name (if not instituti Washington Adventis	st Hospital			Takoma				4c. County of Montgom	ery		
	uneral irector		5. Social Security Number 577 06 9067	6. Sex 7.	Age (In yrs. last bi	irthday) Yrs.	If Under 1 Months	Year If Under Days Hours		. Date of Birth	(MM/DD/YYYY) 1965	9. Birthp Count	try) DC	
, kland	28a-f show any		Usual Residence of Decedent 10a. State 10b. County DC	′	10c. City, Tow	n or Location	WASHI			100	. Citizen of Wha		0d. Inside 0	
) 4 N	or 28a	Director	10e. Street and Number 327 OGLETHOR	RPE STREET 1	N.E.		101. 210 00		011	Tog	U.S		, .	
3 72 hours after death with the Marvland	or items 23a or 28a-f sho	— L		Married Armed Ford	ent Ever in U.S.	If Ye	es, specify C	of Hispanic Original Mexican No specify.	, Puerto Ric		14. Race White	, etc.	n Indian, B	ilack,
affe affe	atural",	q p	3 Widowed 4 D 15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates: ecify only highest grade	completed) 16a	a. Deceden	t's Usual Oc	cupation (Give	kind of work		16b. Kind of Bus			
36 in 72 h	nd be lived within 72 froms and Aental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12	College (1-4				ALES RI			CRICK	ETT	WIREL	ESS
5-00	Hygiene Pother t	S	17. Father's Name (First, Midd		k				,	rst, Middle, Ma	aiden Surname)		- 10	
21215-0036	and Mental Hyg and Mental Hyg 7 is marked oth natic event, the	o Be	JAMES 19a. Informant's Name/Relation						mber or Rura		er, City or Town		Zip Code)	
MD	alth and alth and alth and alth and alth and alth and alth alth alth alth alth alth alth alth		EDNA O'NEAL/ I	MOTHER				RPE STI		I.E. WA	SHINGTO 20c. Location -			
Baltimore,	permit. rages I and 2 shound Department of Health and Me Important: If item 27 is ma injury or other traumatic ev		1 Burial 2 XCremati 4 Donation 5 Other		n State crem	natory or oth ERDALI	herplace) E PARK		10-3	80-09	RIVERD	ALE,	MARY	LAND
Bal	Depar Depar Impor		21. Signatur — Funeral Service	Me	W	300	05 12t	h STRE	EL N.E	T.WASH	NESTEUN	ERAL	28847	LLC
/N	ysician Iedical		23a. Part I. Enter the disease, failure List only one cau. Immediate Cause (Final disea	se on each line.			he mode of	dying, such as	cardiac or re	espiratory arre	st, shock, or hea	art	Between	ate Interval Onset and eath
	aminer		or condition resulting in death											
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence of):									
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760,	cate be executed physician and the burial - transi	Medical	X UNPENDED	AMENDED 238	a <u>, 27 , 28 a-</u> utcome of pregnan	-f,pe	rmE. g	897 11	/19/09	<u> </u>	23d. Date of	delivery		
Box 6876	eath certificat attending phy for use as the	sician/	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓ U	1 Live bir	th nt at time of death	2 Fe	etal death ther (Specil	3 Ector			Month	D.	ay	Year
P.O. B	that the de med by the detached f	by Phys	Part II. Dther significant con			Iting in the	underlying o	ause given in f	Part I.		bacco use contr			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certuir within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed									sy m <u>ed</u> ?	prior to co death?	ompletion of	
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f Vit	Physici er this c rral dire	10 B	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 In	patient 2 🗸 EF	R/Outpatien		A Other			Residence 6	Other	:	
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Divis	al or Atteness after death	Certification:	3 Suicide 6 X C	ould not be etermined (Specify)	of Injury - At homo			office building,		or Town, S	Street and Numb state) 1edo Te			MD
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	ledical Ce	4 ☐ Homicide 29a. Certifier 1 ☐ Certifying one) 2 ✓ Medical E	Physician: To the best examiner:On the basis o	of my knowledge,	death occu	urred at the t	ime, date and popinion, death	place, and d	ue to the caus	e(s) and manne	er as state	ed.	Idiki
	To wit	Med	29b. Signature and title of cer	and manner st.	ated.			License numb	er		29d. Date sig		-	ear)
10_			30. Name and address of pera Zabiullah Ali, M.D.	son who completed caus Assistant Medica		3a) 1	nn Street	, Baltimore	, MD 212	01				
1		tate	31. Date filed (Month Don Ye		gistrar's Signature									
	Regi	strar	MOA A S SOM	Lener	S. par							OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35829 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10 16 2009 5:56 Kathleen M. O'Connor Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Count. **Funeral** Days 1 🗆 M 2 🗓 F Director 172-44-2658 60 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director MD Baltimore City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 Maryland Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Be Completed by 1 X Never Married 2 - Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Chil<u>d Care</u> Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred O'Connor Myrtle Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron O'Connor - Brother 1 Winding Dr. Gettysburg, PA 17325 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other placel ALoysius Cemetin 0/21/09 St. 4 Donation 5 Other (Specify) Littlestown, PA 17340 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PA 17340 ttle's F.H Maple 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ UTERINE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

WIL

OCTOBER

O'CONNOR

KATHLEEN

DHMH 17 Rev 7/2009

Registrar

only one) 29b. Signature and title of

JACKIE JONES,

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

TIMONIUM, MD 21093

hysici		State Registrar		C	Certificate of	Death	10	Reg. No	. 20	09	35830
		1. Decedent's Name (First, Middle, William Loren					2. Date of De Month	Da	3,200 ⁹	ear	3. Time of Death 14:39 PM
/Medic xamir		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Deat			. County of		11137
Aaiiiii	ici	6042 Lockhouse			Sharpsl			W	ashin	ton	County
neral				yrs. last birtho	Months Days	If Under 24 Hrs	(Month, D	rth a <i>y</i> , <i>Ye</i> a <i>r</i>	·) 9		ace (State or Foreign
ctor		220-40-4509 Usual Residence of Decedent	¹₽™ 2□F 67	Yn	S.		April 2	20,1	942 1	West	Virginia
		10a. State 10b. County		c. City, Town o	r Location					10	d. Inside City Limits
Wat be notified at	ctor	Maryland Washing	ton Co. S	Sharpsb	urg						1 □Yes 2 No
2	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wh	at Count	:y?
		6402 Lockhouse			21782				.S.A.		
	Funeral	11. Marital Status 1 □ Never Married 2 Marrie	12. Was Decedent Ever Armed Forces? 1 □Yes 2 No	in U.S.	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (S ban, Mexican, Puer	specify Yes or N to Rican, etc.)	0-	14. Race - Black,	Mhite, el	
	I - I	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:			Specify:	Whit	te
once.	Completed	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usual Occi	upation	rkina	16b.	Kind of Busi	ness/Indi	ustry
	du	Elementary/Secondary (0-12)	College (1-4or 5+)	li	fe. DO NOT use retir Mist	ed)	ning	For	dorol	Corre	ernment
	S	17. Father's Name (First, Middle, La				18. Mother's Nar	ne /First Middle				:ITIMetic
) Be	Forrest Riffle	131/			Leota Ba		, maide.	ir ourname,		
	2	19a. Informant's Name/Relationshi	(Type. Print)	19b. N	failing Address (Stree			ber, City	or Town, St	ate, Zip	Code)
		Sandra Marie Ri	ffle/ Wife	640	02 Lockhou	se Drive.	Sharps	burg	g. Mar	vlar	nd 21782
		20a. Method of Disposition	2	0b. Place of D	isposition (Name of crematory or other pl	ace)	Date	20c. l	ocation - C	ty or Tov	ın, State
		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ll Cemeter	y Oct. 26			gersto	wn,	Maryland
2		21. Signature of Funeral Service Li	censee / / /		22. Name and Add						
o		Dunglas	4. Tuy		1331 East				erstow		D 21742 Approximate
		23a. Part 1. Enter the disease, or c shock, or head failure. List or Immediate Cause (Final	on plications that caused the hily one cause on each tine.	peath. Do not	enter the mode of dy	ring, such as cardia	c or respiratory	arrest,			Interval Between Onset and Death
n al		disease or condition resulting in death)	a. Idiopa Due to (or at a co	thie 1	Dulmora	7 tibe	0515		-	_	1 year
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		resulting in death/ Last	Due to (or as a co	nsequence of):							
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	n/Medica	IF FEMALE:	23c. If yes, outcome of p						23d. Date	of deliver	·V
	ician/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy			23d. Date Mont		ry Day Year
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State of Maryland / Department of Health and Mental Hygiene

			For State C	i waryianu	'	rtment of He tificate of D				009 3	5831
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	e of Death
	/Medic		Joseph Francis	Raley				October			30 p ^M
3	Examin	er	4a. Facility Name (If not institution, give street and not 49256 Wynne Road	mber)		4b. City, Town, or L Ridge			4c. County o	Mary's	
raph	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			ite or Foreign
	Director		214-30-0553 ^{1⊠M 2□ F}	84	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 12/02/	1924	9. Birthplace (Sta Country) Mar	yland
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation					e City Limits
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	eath v	eral	49256 Wynne Road	edent Ever in U.S.	13 V	20680	panic Origin? (Sp	ecify Yes or No		- American India	٦,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 1 □ Never Married 2 ▼ Married 1 □ Yes If Yes, G Year or I	orces? 2 X No ve		Vas Decedent of His fYes, specify Cuban □Yes 2⊠ No	Specify:	Rican, etc.)	Black Specify:	, White, etc. White	,
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ore,	of Hei		20a. Method of Disposition	20b. Pla	ace of Dispos metery, cren	sition (Name of natory or other place)	Date	20c. Location - 0	City or Town, Stat	9
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Baltimore, Maryland 21215-0036	permit. Departr Imports any inji		21. Signature of uneral despression name Edward N. Brinsfield,	Jr. M00		Name and Address Holls					
			23a. Part 1. Enter the disease, or complications that	caused the death.	Do not ente	er the mode of dying	, such as cardiac	or respiratory a			mate Between and Death
	Physician		Immediate Cause (Final disease or condition	elral	Voes	culav	OCCIO	lent		Onset	ind Death
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Division of Vital Records,	The law requires that the death cert ate has been signed by the attendingage 2 should be detached for use a	Completed by F	Part II. Other significant conditions contributing to	eath but not resul	ting in the ut	nderlying cause giver	n in Part I.	23e. Did t	obacco use contr Yes 2 No	3 ☐ Probably 4	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the 2 ✓ Medical Examiner: On the and ma	e best of my know basis of examinati nner stated.	vledge, deat ion and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occur	, and due to the rred at the time,	cause(s) and ma date and place, a	inner as stated. and due to the cai	use(s)
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	6		MANAMA	120		03	1982	- MU	10-		7
	×~		30. Name and address of person who completed cal	ise of death (Item	23a) (Type,	1 1 1 1	22576 Mac	Arthur	Blvd (519 ia. MD
	Sta	te	31. Date filed (Month) Par 2218 2009. 32.	egistrar's Signati	ure	,	.2570 Flac	.ii CHUI	DIVU.,	Jarri VIII.	La, PID
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Irvin Roberson 3:55 Ам 2009 Medical October 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9010 Briarcroft Lane Laurel Prince George's Social Security Number 8. Date of Birth
(Month, Day, Year)
June 25, 1935 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Months Hours Min. 1 🕅 M 2 🗆 F Country Director 237-52-0017 74 Robersonville, NC Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Laurel 10f. Zip Code 10g. Citizen of What Country? ms 23a Funeral 9010 Briarcroft Lane 20708 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced ed with. ral Hygiene. raer than "natu." ه Medical Ey Completed Year or Dates. 1954-1957 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Service Manager marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Irvin Roberson Helen Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 1907 Fall Hill Avenue, Fredericksburg, VA 22401 Pamela Heflin / Daughter or other Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1.
Department of Important: If its any injury or or cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 10/30/2009 4 Donation 5 Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA RAY Rigers Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Pancreas Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🖾 Residence 6 🗌 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA ieral Director. After thi filled in by the funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be

Records, of Vital To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director, After it completed filled in by the funeral Division

State Registrar

Medical

29a. Certifier

(Check 29b. Signat

31. Date filed (Month, Day, Yea

OCT 2 6 2009

Martin D. Weltz, 7525 Greenway Center Drive, Suite 205, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D23743

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10/23/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:35p. M Helen Mae SIGLER October 23, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Autumn Assisted Living Hagerstown Washington 8. Date of Birth (Month, Day,
June 2, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours 86 219-12-0214 Director 1923 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show 10d. Inside City Limits Maryland Washington Hagerstown Director 1 ☐ Yes 2K No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Item 1, ury or other traumatic event, Item 1, ury at 1, ury and 1, ury or other traumatic event, Item 1, ury or other traumatic event, Item 1, ury at 1, ury 1, 11423 Rock Hill Road 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: white ģ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clothing manufacture pressor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Bartlett Agnes Jordan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve E. Sigler - son 12223 Bucky Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date cemetery, crematory or other place)
Cedar Lawn Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October permit. Page Department o Important: If any injury or once. Hagerstown, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Puneral Service Licenses 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alphinois Dair **Physician** 1 Sly Sin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause for the country of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached a 1 ☐Yes 2 ☐No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ nomente 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ € finknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 □ No 1 □ Yes 2 A ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23200 tre mo D00180 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ASA DT

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32. Registrar's Signature

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AGERSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10-31-2009 **Physician** 10:20 A^M Betty P. Shumaker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Citizens Care & Rehab Center Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1 □ M 2 T F Yrs. 6-20-1932 MD **Director** 217-28-5530 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "Actical Examinating that be notified at 1 Yes 2 No Director Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 800 Motter Avenue Apt # 504 21701 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐MNo If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Cleaning House Keeping permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othin any Injury or other traumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Guy Barthlow Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 800 Motter Avenue Apt 504 Frederick, MD 21701 Husband Howard Shumaker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Cremation 11-2-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Fungfal Septce Liven 106 East Church Street Frederick, MD 21701 M01176 23. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death s Jck, or heart failu immo ate Cause (Final ase or condition resulting in death) ck, or heart failure. List only one cause on each line Physician TASTATIC BLADDER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) □Yes a∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □Yes 2 1 No e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 Insuring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier N1) 20061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE - Hy FREDERICK

Registrar

DHMH 17 Rev 1/2001

State

GAFFAR

31. Date filed (Month, Day, Year)

7061

801

32. Regis ar's Signature

DIL

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25, October 2009 Guffrie Smith 9:35 p.m^M. Matthew Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lexington Park
if Under 1 Year | If Under 24 Hrs. St. Mary's Chesapeake Shores Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Yrs 216-14-8974 Director 88 06/01/1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Expr. in ar must be untilled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland St. Mary's Scotland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 49805 Fresh Pond Neck Road 20687 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bus Contractor Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ဥ Dozie Wood Smith Bertha Holley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Morton/Daughter 45839 North Springsteen Ct., California, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/29/2009 Great Mills, Maryland Evergreen Memorial 21. Signature Triberal Service Licensee

22. Name and Address of Facility Brinsfield Funeral Hornerton MD

Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Dementia Years /Medical Due to (or as a consequence of): Examiner Coronary Arterial Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 🗌 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 ☐ Yes ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the l within 2 To the l 29b. Signature and title of quitifier 29c. License number 26262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6362 Dockser, Falls Church, VA Samuel Kleiman, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.Q State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Joan Kathryn Steele 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 28,1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2**⊠** F 217-42-5688 66 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Extrict or restited at Director Dorchester 1 ☐ Yes 2 No East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3909 Lee Court 21631 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify: <u>ک</u> white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o Charles Edgar Shenton Sr. ဂ္ Florence Virginia Geib 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Steele permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trong. husband 3909 Lee Court, East New Market, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 10/27/09 Cambridge, MD 21. Signature of F∎neral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. us dom 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sapsis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lyncry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 - No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryla

Baltimore, Maryland 21215-0036

Foan Sieele, K

State Registrar

THANKY NOMAN 31. Date filed (Month, Day, Year)

(Check only

29b. Signature and title of certifier

503 BYRN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

047924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

MD 216/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month DOROTHY J. STITES 09 7:00F 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverda Genesis If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Funeral Months 1 □ M 2 🛛 F Davs Hours Director 208-16-7425 84 November 19,1924 Plymouth, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must to rudified at Director 1 X Yes 2 □ No Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1716 Merrimac Drive 20783 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Government Railroad Retirement Board Pages 1 and 2 should be filed vent of Health and Mental Hygic ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jones Mary Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tod Stites / Son 1716 Merrimac Drive, Adelphi, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 10/26/2009 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Leins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □No 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Oursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 🗆 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064208

State Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saadi a
31. Date filed (Month, Day,

OCT 2 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Julia Topolski 2009 Catherine 28, October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year) 12/29/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days 1 □ M 2 🔀 F Months Hours Min. Director 81 219-22-8560 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo St. Mary's Lexington Park Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 45796 Lord Baltimore Way 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Tes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify \$ White 3 Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rural Postal Carrier U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Edith Mercer Harry Ε. Bush ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41450 Burnt Mill Drive, Hollywood, MD 20636 Michael T. Topolski/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/31/2009 Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Loward M. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final **Physician** OCARd disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and is the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ANo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 2 No 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation T Natural Cocation (Str. et and Number or Rural Route Number, City or Town, State) 45796 Lord Balto Way SAM 1 ☐ Yes 2 No 10.28.09 2 KX ccident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 24 hours a Lexington Park, MD

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Boyd, M.D. 25365 Point Lookout Rd., Leonardtown, MD 20650

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John David Thompson 25, October 2009 5:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours 218-54-6690 Director 60 06/12/1949 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the involcal Experiment must be notified in Director 1 ☐ Yes 2 🗓 No Maryland St. Mary's Hollywood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 43555 John B. Thompson Road death 1 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ρ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting and Mental Hygin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Briscoe Thompson Erma Joy Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s.
Department of Health ar
Important: If item 27 is,
any injury or other traus Virginia Lacey/Sister 38533 Sugar Hole Road, Avenue, MD 20609 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Chapel Cemetery 10/30/2009 Hollywood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons 22955 Hollywood Rd., Leonardtown, MD 20650 M01206 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2□No P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 P No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No Division of Vital 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifit completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🐼 No 2 ER/Outpatient 3 DOA Certification: To 1 Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

360

State Registrar 30. Name and address

James P.

Jarboe,

Three Notch Road, Hollywood, MD

20636

s of person who completed cause of death (Item 23a) (Type, Print)

24035

gistrar's Signature

09-08131 Val

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

0

erie Tull	1	State of Maryland / Department - For State Certificate		Hygiene Reg. N	2000	2501
Physicia		legistrar 1. Decedent's Name (First, Middle,Last)	0, 500	2. Date of Death	- U 3. Tit	ne of Death 3 0
dical Examir		Valerie Claire Tull		Month Da October 19, 2		153 hrs
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Do Baltimore	eath	4c. County of Death	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4Hrs. 8. Date of Birth (N	/M/DD/YYYY) 9. Birthplac	e (State or d
Director	- 1	24	Yrs. Months Days Hours	May 7,	1985 Country)	
	ļ	Usual Residence of Decedent	cotion		10d.	Inside City Limits
bw any		10a. State 10b. County 10c. City, Town or Lo	Westmi	inster		Yes 2 No
ryland ia-f sh	황	10e. Street and Number	10f. Zip Code		Citizen of What Country?	
with the Maryland s 23a or 28a-f show s t notified at once.	Directo	1810 Stone Chapel Road		157	USA	
h with ems 23	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Ir White, etc.	idian, Black,
er deat , or it		Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		white Specify:	
urs aft itural" amine	a p	15 Pacedent's Education (Specify only highest grade completed) 16a Dece	edent's Usual Occupation (Give kind ng most of working life. DO NOT use		Sb. Kind of Business/Indust	try
6 172 hc an "ng cal Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	sidential Caregi	1	Carroll Co	unty
-003 within giene. her th	mo.	17. Father's Name (First, Middle, Last)	_	Name (First, Middle, Mai	den Surname)	
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be C	Larry Wayne Tull		Elizabeth		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	۵	19a. Informant's Name/Relationship (Type, Print) Ann E. Tull, mother 186	ailing Address (Street and Number 10 Stone Chapel	er or Rural Route Numbe Road . Westm	r, City or Town, State, Zip Linster, MD 2	21157
Baltimore, MD bemit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumating		20a. Method of Disposition 20b. Place of Di	isposition (Name of cemetery.		20c. Location - City or Town	
nore ages 1 nt of H nt: If i		Carro	or other place) 11 Crematory	10/22/2009	Winfield,	MD
altin mit. P partme portan ury or	1	4 Donation 5 Other Specify:	22. Name and Address of Facility	Myers-Durbo	raw Funeral	Home
		23a.Part I. Enter the disease, or complications that caused the death. Do not en	91 Willis Stree			pproximate Interval
Physician //i	_	failure. List only one cause on each line.	nor and mode or cyring cook as asset		В	Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				
	Ę	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause				
ecuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of):				
O, e be execute sician and burial - trar	edical	UNPENDED AMENDED				
760, icate be physicate bur		IF FEMALE: 23c. If yes, outcome of pregnancy 1 I ive birth	Fetal death 3 Ectopic	pregnancy	23d. Date of delivery Month Day	Year
Box 6876(death certificate the attending phy ed for use as the b	cian	past 12 months? Pregnant at time of death 5	Other (Specify)			
Boy te death the att	Physician/M	1 Yes 2 No 9 ✓ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Par	t I 23e. Did tob	acco use contribute to the	cause of death?
ires that the signed by	by P	Part II. Other significant conditions contributing to death but not resulting in	The underlying cause given in Fan		2 No 3 Probabl	
rds, requires been sig	eted			24a. Was ar		sy findings available pletion of cause of
e law re has be ge 2 sh	Completed			perform 1 ✓ Yes 2	ned? death?	2 No
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Be Co	25. Was case referred to medical	26.Place of Death (
Vita hysicis this ce	To B	1 ✓ Yes 2 No			Residence 6 Other:	
n of ding Ph	 	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tin (Month, Day Year) 28b. Tin (Month, Day Year) 1404 h	, ,	Driver auto a		
Division tal or Attendir rs after death.	icati	2 Accident Investigation 28e. Place of Injury - At home, farm	n, street, factory, office building, etc		treet and Number or Rural	Route Number, City
Div oital or ours after ral Di	Certification:	4 Homicide determined (Specify) Major Road			Road and Route 27, We	estminster, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the c	ause(s)
To the within To the comp	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	
MJL	_	Custz	O.C.M.E.		October 20, 2009	
10		30. Name and address of person who completed cause of death (Item 23a)		04004		
		20 Dec trario Signaturo	enn Street, Baltimore, MD	21201		
S Regis	state stra		backet			
DHMH 17 Rev 1/			GINAL			

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Henry Tiffany <u>October</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 355 Bard Cameron Road Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1**X**XM 2□ F Director 210-09-7143 93 July 12,1916 Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code Funeral 355 Bard Cameron Road 21911 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 If Yes, Give Maryland 21215-0036 1 □Yes 2√TNo ≥ Specify: 3√Widowed 4 □ Divorced Year or Dates:1939-41 Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civilian Gunner Foreman permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ည James Edward Tiffany Harriet Filer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Davis / Daughter 355 Bard Cameron Road, Rising Sun, Maryland 21911 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State October 0 Harford Memorial 4 ☐ Donation 5 ☐ Other (Specify) 30, 2009 22. Name and Address of Facility Crouch Funeral Home ural Service 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by has certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of

23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □Yes 2 No 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Day

2009

4c. County of Death

10g. Citizen of What Country?

<u>United States</u>

Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, State

Aberdeen, Maryland

Approximate Interval Between Onset and Death

10 year's

Government

Cecil

7:30 ₽M

9. Birthplace (State or Foreign Country) Johnstown Pennsylvania

10d. Inside City Limits

1 ☐Yes 2 No

THIVA

After 1

after death

24 hours a

within 2 To the I

Medical

1 Natural

3 Suicide

29a, Certifie (Check only one)

29b. Signature

4 ☐ Homicide

5 Pending

and little of certifie

31. Date filed (Month, Day, Year)

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

incent A. GIMINARS, To

State Registrar

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28c. Injury at Work?

29c. License number

40054439

4/8 North Avenue, Such 310, Bol Air, MD 21014

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Urbanek Joseph Glen 26, 2009 11:45 a October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45352 Sypher Road California St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Director 214-72-4048 52 07/12/1957 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural" any injury or other traumatic excessions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45352 Sypher Road 20619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferdinand J. Urbanek June Carter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret E. Medlin/Friend 45352 Sypher Rd., California, MD 20619 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols 10/31/2009 | Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Si natur of Funeral Service Lice see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward W. Brinsfield, 22955 Hollywood Rd., Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HICOHOUC **Physiclan** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) □Yes 2□No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5XXAesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation iours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address

31. Date filed (Month, Day,

Jennifer Schmidt

Year,

Registrar's Signa

person who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

			1 - For State of Maryland / Dep	ertificate of Death		. No.	33043
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
•	/Medic	al	Joseph Edward Urban, Jr.	1 # 67 T	October 2		12:18pm ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4158 Salem Bottom Road	4b. City, Town, or Location of Death Westminster	1	4c. County of Death Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		216-38-6910 X□ M 2□ F 67 Yrs. Usual Residence of Decedent	Months Days Hours Min.	Apr. 20 1	942	MD
	yland how		10a. State 10b. County 10c. City, Town or L	ocation	-		10d. Inside City Limits
	e Mar la-fsl	ctor	MD Carroll	Westminster			1 □Yes 2 🙀 No
	ith the	Dire	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	
	s 23a	eral	4158 Salem Bottom Road	21157			SA
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Modical Exp. injury in the Province one.	by Funeral Director	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏋 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
215-0036	2 hour	ted }	15. Decedent's Education 16a, Dece	edent's Usual Occupation	16	b. Kind of Business/fr	ndustry
Z	thin 7 ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		_	
7	led wi	S		ctrical Engineer		Engineeri	1g
yland	l be fill hed other	Be	17. Father's Name (First, Middle, Last) Joseph Edward Urban, Sr.		ne (First, Middle, Mai nna Irma D	· ·	
Ž	should nd Me mark matic	은		ing Address (Street and Number or Ru			n Code)
Na Na	and 2 sealth ar		1 1 27	Salem Bottom Road			, , ,
ore ore	jes 1 g t of He If item or othe		20a. Method of Disposition 20b. Place of Disposition 1 Rurial 2 Wicremation 3 Removal from State	osition (Name of ematory or other place)	Date 20	c. Location - City or T	own, State
Банттоге	t. Pag tment tant: ijury o			ty Cremation 10/23		ykesville	, MD
n D	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	2 Namandadnerfaciinomi O Box 195 Sykesvil	E & CHAPEL	, P.A. 784	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	i,	Approximate Interval Between
	Physician	Y Y	Immediate Cause (Final disease or condition	ANCEA			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				71 - (1.1
		in in	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Entire Underlying Cause (Disease or Injury that initiated events				
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O. DOX	e death c he attend led for us	Physician/	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	very Day Year
Ľ	hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I	23e. Did tohar	cco use contribute to	the cause of death?
cords,	equires ten signe ould be o	ted by			1 □ Yes	~	bably 4 ☐ Unknown
ם בי	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed			24a. Was an autopsy performe 1 ☐ Yes 2,	prior to co	opsy findings available ompletion of cause of
N I G	certific rector,	Be	25. Was case referred to medical examiner?	Other	th (Check only one)		
5	ling Phys n. After this funeral dii	.T	1 ☐ Yes 2 No Properties 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a, Date of Injury 28b, Time of Death	ant 3 DOA 4 I Nursing H	ome 5 Residence 28d. Describe how	e 6 Other (Speci	(fy)
5	nding ath. r: Afte e fune	atior	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □Yes 2 □ No		,,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cau rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th Within Comp	Me	29b. Signature and title of configuration	29c. License number		. Date signed (Month,	
	1		Mour Ree	D28768		10/20/2	009
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, HANEO ELEVAN SWAGEN SOUNS HOPE)	Print) Bell	mine M	10/20/2	1-1000
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	ar	OCT 21 2009 Deneur S. 19	parker			

09-07881 Mary Valenzuela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 10, 2009 1923 hrs Medical Examiner Mary Elizabeth Valenzuela 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Clarksville Howard 12540 Route 108 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex **Funeral** Country Months Davs Hours Min Director 08/27/1956 Chile 1 M 2 X F 031-50-3678 Usual Residence of Decedent 10d. Inside City Limits any 10b. County 10c. City, Town or Location 1 X Yes 2 No 23a or 28a-f show notified at once. Bethesda Maryland Montgomery with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e, Street and Number 7910 Sleaford Place 20814 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Pages I and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be 1 Armed Forces? 1 Never Married 2 Married Yes 2 X No Widowed 4 X Divorced Give Year 1 X Yes No specify: Chilean Specify: Other White چ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Millenium Challenge 21215-0036 5+ Executive Corp. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raimundo Valenzuela Dorothy Bowie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Dania Straughan/Daughter 7910 Sleaford Place; Bethesda, MD 20814 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State 10/27/09 Brentwood, Maryland ment mportant: Ft. Lincoln Crematory Donation 5 Other Specify: 22. Name and Address of Facility Simple_Tribute permit. 21. Signature of Euneral Service Licenses 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician List only of cause on each line Between Onset and failu Medical Death a. Head Injuries Imme dat/ Cause (Fire) disease xaminer or consilion resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and transi Physician/Medical g physician a the burial -UNPENDED AMENDED death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending properties of the second Year Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death Other (Specify) 5 been signed by the atter 1 Yes 2 V No 9 Unknown 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>چ</u> Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? . death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other, Hospital: 1 examiner? Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this 1 V Yes 70 funeral 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Driver of auto involved in collision Oct 10, 2009 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 1916 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 12540 Route 108, Clarksville, MD determined (Specify) Roadway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 October 11, 2009 O.C.M.E.

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

30 Name and address of

Jack Titus MD.

6

31. Date filed (N

111 Penn Street, Baltimore, MD 21201

erson who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

9-08326		Please Type or Print in Black							egib	ole.		
Charles Henry V		I- For State (epartment d Ce <i>rtificate</i> d			a Ment	аі пу	giene	Reg. N	200	9 35845	
Physicia Medical Exami	in/ ner	Registrar 1. Decedent's Name (First, Middle,Last) Charles Henry Wills, Jr.					2	Date of D Month October	eath	у ^{Үеаг} 2009	3. Time of Death 0705 hrs	
		4a. Facility Name (if not institution, give street and number) Three Notch Road and Poplar Ridge Road			ty, Town, or xington F		Death			4c. County of St. Mary's		
Funeral		5. Social Security Number 6. Sex 7. Age (In y	yrs. last birthday)	If U	Jnder 1 Yea	r If Under	_	8. Date of	Birth (N	I MM/DD/YYYY)	9. Birthplace (State or Foreign	
Director		217-98-0135 1XM 2 F 42	Y	rs.	onths Day	s Hours	Min.	May	20,	1967	Country) MD	
any	ŀ	Usual Residence of Decedent 10a, State 10b, County 10c.	City, Town or Loc	ation							10d. Inside City Lir	
Aaryland 28a-f show 1 at one	ē	MD St. Mary's I	exingto		rk Zip Code				100.0	Citizen of Wh	1 Yes 2 X	No
the Mar 3a or 28a	Director	21753 N. Essex Drive			20653				log. v	USa	at Gourney:	
ath with tems 2.	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever Armed Forces?	ľ		cedent of His ecify Cubar				No-	14. Race White	American Indian, Black, etc.	
after de	by Fu	3 Widowed 4 Divorced If Yes, Giva Yaar or Dates:		Yes	2 X No	specify:				Specify:	White	
hours a		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during		sual Occupa f working life						iness/Industry	
036 ithin 72 ne. r than '	Completed	12	Main	tena	nce T				C:	ity Sta	c St.Mary's ate Governme	nt
21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Charles Henry Wills						First, Midd n Und		den Surname)		
212 ould be d Ments s mark lic even	ToB	19a. Informant's Name/Relationship (Type, Print)		•		et and Num	ber or Ru	ıral Route	Number	r, City or Towr	, State, Zip Code)	
MD 2 sho salth and 2 sho em 27 is		Rebecca Holly Wills - Wife 20a. Method of Disposition	217.				ive,	Lexi			City or Town, State	
MOFE ages 1 and of He int of He other t		1 X Burial 2 Cremation 3 Removal from State	crematory or Charles	other pl	ace)		10/3	1/200	9 L	eonard	town, MD	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at one.		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Michael K. Gardiner per DVR	Gardens M	Name atti	and Addres	s of Facility -Gard	iner	Fune	ra1	Home,	P.A.	
Physician		23a. Part I. Enter the disease, or complications that caused the c	leath. Do not ente	er the mo	ode of dying	, such as ca	erdiac or	respiratory	arrest,	MD 206 shock, or hea	rt Approximate Inte	
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence)	200 00:								Death	
		Sequentially list conditions, b.					-					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	nce of):									
cuted and transit		events resulting in death) Last Due to (or as a consequent d.	nce of):									
be exectician and inial - tr	dical	UNPENDED X AMENDED # 21	per fh,	g897	7,11/1	2/09d	hb					
Box 68760, e death certificate be ex the attending physician ed for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of		Fetal de	eath 3	Ectopic	pregnar	псу		23d. Date of Month	delivery Day Year	
Ox 68 eath certif	sicia	past 12 months? 1 Yes 2 No 9 Unknown g Unknown		Other ((Specify)				.			
O. B at the da d by the		Part II. Other significant conditions contributing to death but	not resulting in th	e under	lying cause	given in Pa	rt I.	23e. D			bute to the cause of death	
S, P. uires th n signed Id be de	ed by							1 242 V	Yes /as an		Probably 4 V Unkno	
Cord law rec has bee	Completed						 -	a	utopsy erforme	ed?	rior to completion of cause leath?	e of
I Re In: The rrificate for, pag		25. Was case referred to medical			26.Plac	ce of Death	(Check c		es 2	No 1	Yes 2 No	0
Vita Physicia r this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient			DOA	Other ₄		Home 5			Other: Scene	
on of nding Pl th. r: After		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) Oct 27, 2009	28b. Time 0700 hrs	of Injury	1 —	ury at Work Yes 2 🗸	No.		d driv		ale involved in motor	•
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exervithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury		treet, fac	ctory, office	building, et	c.	28f. Locati	on (Stre	eet and Numb	er or Rural Route Number,	
Diospital		4 Homicide determined (Specify) Roadw 29a. Certifier 1 Certifying Physician: To the best of my knot		ourrod s	at the time	date and nis					Roads, Lexington Park	<, M
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or investi	igation, i	in my opinic	on, death oc	curred a	the time,	late and	d place, and o	ue to the cause(s)	
F % F 3	Me	29b. Signature and title of certifier		\		.M.E.	001	ME		9d. Date sign October 28	ed (Month, Day, Year)	
		30. Name and address of person who completed cause of death	(Item 23a)	٥.		, (VI. L.	301				., 2000	
		Theodore M. King, Jr., MD. Assistant Medi	cal Examiner	111	1 Penn S	treet, Ba	Itimore	, MD 21	201			
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's S	gnature	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	arylan		artment tificate			and M	lental Hy	-	000	0	05016
			Decedent's Name (First, Middle, Last	st)			timoato	-012	<u>outir</u>		2. Date of De			7	3. Time of Death
	Physicia Medic		Edith Mae WHITE								Chober	Da 274	y 200	9	4:38 AM
	Examin	er	4a. Facility Name (if not institution, give Washington Count	y Hospital			На	gers	cocation of town			40	County of D Washi	ngt	
	Funeral Director		5. Social Security Number 218–30–8626	9X 7. Age	e (In yrs. Ia 78	ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs Min.	8. Date of Bir (Month, Da NOV •	th y, Year) I	930	Birthpl Countr Ma	ace (State or Foreign ryland
	and show lat	b	10a. State 10b. County		10c. City	y, Town or Lo	cation							10	d. Inside City Limits
	Maryla 28a-f otified	rect	Maryland Washin	gton		На	gerst	own							1 🗌 Yes 2 🏻 No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 17537 Cedar Lawn	Drive			10f. Zip		740				tizen of What SA	Count	ry?
920	s filed within 72 hours after death with the Maryland tal Hygene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.			Vas Decede f Yes, speci			gin? (Spe , Puerto i	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	hite, et	
1215-0	hin 72 hou ne. than "natu ne Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	de completed) College (1-4 or 5	i+)	life. Do	kind of work O NOT use	k done du retired)	ring most		ng	16b. k	Kind of Busine		·
Maryland 21215-0036	ild be filed with Mental Hygien tarked other t atic event, the	To Be C	12 17. Father's Name (First, Middle, Last) Allen L. Leasure	0		I	loral		18. Mothe	er's Name	e (First, Middle,		floi Surname)	rist	
	2 shouth and it is in traum		19a. Informant's Name/Relationship (T) Earnest F. White		ì						Route Numbers				
Baltimore,	- - = 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		C	lace of Disponentery, crem	natory or oth	her place,			8/09		ocation - City		_{m, State} Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	nunn	uC	/					NICH F				1740
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	olications that caused ne cause on each line	the death		r the mode	of dying,	such as o	cardiac o					Approximate Interval Between Onset and Death
,	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a	consequ L		()	7 10	nen	25-					
	uted d ansit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	consequ	ence of):									
09	ate be executed shysician and the burial-transit	dical Examine	resulting in death) Last	Due to (or as a	D	ence of):	3								
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o uo	ending eath. or: After he fune	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day,		injury	M 201	work?	es 2 🗆 i		8d. Describe h	iow injur	y occurred		
Divisi	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injui building, etc.	. (Specify)						8f. Location (S City or Tow	n, State,)		oute Number,
	Hosp 24 hou Funer eted fil	Medical	(Check 2 Medical Exami	ner: On the best of r	amination	and/or investi	gation, in m	v opinion.	death occ	curred at	the time, date a	nd place	and due to the	e caus	e(s) and manner stated.
	To the within Comple	Σ	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Fractioner: 10 the t	Jest of my	n iowieage, a		License r		апо ріасє			s) and manner te signed (Mo		
	15		> M				\mathbb{D}	63.	502			10/	26/07		
_	10		30. Name and address of person who c	ompleted cause of de	1	23a) (Type, Pi		n	MD	Å	1740				
	Stat Registra		31. Date filed (Month, Day, Year) OCT 28 20	09 32. Registra	r's Signati	D. Ja	well							_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35847 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** October 24, 2009 Mary Alberta Woodland 12:11 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🕅 F 220-16-5050 Director 87 10/26/1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be men waren.
ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural" or items 23a or 28a-f show
itury or other traumatic event, the Pedical Exaction must be notified at Director 1 ☐ Yes 2 X No Maryland | St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26140 Loveville Road 20659 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Maintenance Worker Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ John Henry Chase Mary Spears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Chase/Nephew 46405_Kent Drive, Lexington Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department o Important: If i any injury or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/2009 | Mechanicsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Galilee Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, P.A. ignature of Funeral Service License Ward No Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC BRRHYTMA **Physician** MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner N /NUTES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed CAD resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 □ Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Naccident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 009 MO D0068989 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) P.O Leonar atown OROGBEM BO 524 mo LUNDE 31. Date filed (Month) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician JAMES WILLIAMS OCTOBER 22 2009 2:19 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PATUXENT RIVER HEALTH & REHAB LAUREL PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F Director 216-28-9785 73 SOUTH CAROLINA MAY 22 1936 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f shorex are intermed at Examiner must be notified at 1 XYes 2 □ No Director PRINCE GEORGE'S COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6200 WEST CHESTER PARK DRIVE 20740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No army If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. BLACK þ Specify: 3 ☐ Widowed 4 🛣 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) 12TH ENTREPRENEUR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT J. WILLIAMS MARIE CUNNINGHAM 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY KYLE/FRIEND 522 LYONSHEAD ROAD FAYETTEVILLE, NORTH CAROLINA 28311 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages nent of I permit. Pages Department of Important; If it any Injury or o 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ARLINGTON CEMTERY 11/4/2009 ARLINGTON, VIRGINIA 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GANGRENE LEG WITH SEPSIS /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) P.0. ☐Yes 2 ☐No 9 🗌 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed . Were autopsy findings available prior to completion of cause of death? autopsy The performed' 1 ☐Yes 2 ▼No 1∐Yes 2XNo funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🙀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

or Attending Physician: Votre more after death.

To the Funeral Director: After the funeral pirector of the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in bird

State

Registrar

Medical

determined

4 Homicide

29b. Signature and title of certifie

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED SADIQ M.D. 14333 LAUREL BOWIE ROAD # 208 LAUREL, MARYLAND 20708 32. Registr r's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24721

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

OCTOBER 23, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryla	-	artment of F rtificate of I		_	giene Reg. No. 2	009	35850
1	Physici	an	Decedent's Name (First, Middle,					2. Date of De Month	Day	Year	3. Time of Death
,	/Medio		HUGH 4a. Facility Name (If not institution,	W. WIGG:	LNS	4b. City, Town, or	Location of De	Octoba		ty of Death	12"AM
1	Examin	iei	DOCTOR'S HOSP			LANHAM				CE GEO	RGE 'S
	Funeral Director		5. Social Security Number 065-44-8186	6. Sex 1 X M 2 ☐ F 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, D		9. Birthp Coun	lace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				11	0d. Inside City Limits
	tth with the Marylan 23a or 28a-f show	to									1 X Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number	GEURGE 5 1	RIVERDA	10f. Zip Code			10g. Citizen o	of What Coun	try?
	th with	al D	5626 67th AVEN	UE		20737			TRINAD	AD	
	r dea	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin? In, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 14. R	ace - Americ lack, White, e	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evantinat must be notified a once.	þ	1 ☐ Never Married 2 🔯 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ∐Yes 2 XNo If Yes, Give Year or Dates:		1⊡Yes 2MNo	Specify:	,	Spec		ACK
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121	within ene. than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
d 2	filed v Hygid Sther		12TH 17. Father's Name (First, Middle, L	ast)	ENVIR	ONMENTAL	MAINTE 18. Mother's N	NANCE lame (First, Middle	PRTV , Maiden Surna		
1661NS, Hugh altimore, Maryland	12 should be filed within 'n and Mental Hygiene. 7 Is marked other than "raumatic event, the Mental Hygiene.	To Be	GRANVILLE WI	GGINS			MAY	(GOODRID	GE	
⊥ lar	2 sho and Is ma	1	19a. Informant's Name/Relationsh	p (Type. Print)	19b. Mailir	ng Address (Street a	and Number or	Rural Route Numb	er, City or Tow	ın, State, Zip	Code)
₹5;	1 and Health em 27 ther to		BERNADETTE W		5626	67TH AVE	NUE RIV	ERDALE, M	ARYLAND	20737	7
GGINS timore,	nt of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	B ☐ Removal from State		natory or other plac		Date	20c. Location	•	
Ei S	nit. Pa artme ortant injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Fungeral Service L	**		CEMETERY 2. Name and Addres		24-2009 J. B.	LANDOV TENKTNS		AL HOME
≥ g	permi Depar Impor any ir	l p	1	3			,	OAD LAND			
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that caused the de	ath. Do not ent	er the mode of dyin	g, such as card	liac or respiratory a	JVE.K., MA irrest,	RYLANI	20785 Approximate Interval Between
-	Physician	1	Immediate Cause (Final disease or condition	Anax	10 E	ncep	halo	athy	65		Onset and Death
	/Medical Examiner		resulting in death)	D le to (or a) a conse	equence of):	10 -	1	,			
	Lxammer	<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	1 / O 7	Thyro	disn	1			
	uted d ansit	Examiner	Cause (Disease or injury	Due to (or as a conse	400	tens	100				
o,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a conse	equance of):	10					
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	ertific Jing ple e as t	Med	IF FEMALE:								
Вох	attend for us	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	tal death 3	Ectopic pregnancy Other (specify)	/		10	Date of delive Month	ery Day Year
0	the de	ysic	1 □Yes 2 □No 9 □ Unknown	9 🗆 Unknown	idealli 5L	Totner (specify)					
о, С.	requires that the death certific been signed by the attending p should be detached for use as	by Pt	Part II. Other significant condition	s contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to th	e cause of death?
ord	v require been sig should b							_ 1 🗆	Yes 2□ No	3 ☐ Prob	ably 4 Unknown
ecc	as aw	Completed						24a. Was	psy		osy findings available inpletion of cause of
<u>m</u>	ding Physician: The I h. After this certificate ha funeral director, page							perfo 1 □ Yes	ormed?	death? 1 □ Yes	2 🙀 No
V.	Physician: r this certific ral director, j	Be	25. Was case referred to medical examiner?	Hospital:		Othe	25.	eath (Check only			
of	y Physer this eral di	2 1	1 ☐ Yes 2 ANo 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	4 ⊔ Nursing ⁄ at	Home 5 ☐ Resi			/)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day, Year)	Injury	Work	? Yes 2 ∐ No		,,		
Division of Vital Records,	or Atte after dez Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		home, farm, stre cify)	eet, factory, office		28f. Location (City or To	Street and Nur wn, State)	mber or Rura	Route Number,
Ω	pital of urs af eral D		00- 0-45-	4				W.			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my ki xaminer: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tire vestigation, in my o	ne, date and pla pinion, death oc	ace, and due to the ccurred at the time,	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ned (Month, I	Day, Year)
			made	Melebe		D52	500		OCT	20	2009
i R	31		30. Name and oddress of person w	ho completed cause of death (Ite	em 23a) (Type,	Print)	0.5 /	./.	1 2 4	7.0.1	
	Sta	te	31. Date filed (Month Pay Year)	du L Wah che	8118 G	OOL LUCK	KD, LA	WHAM N	10 20	106	
or a	Registr	ar	001202003	cenera p. 19	aver						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 1 9 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paltimor Randallstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)

Yrs. **Funeral** Months Days Hours 1 XM 2 □ F Director 04 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, I'm Modical Examiner must be notified at once. Randallstown Baltimore 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Cowt 21133 Herrara 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

2th, grade College (1-4or 5+) robation 1101 veurs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Randallstown MD 21133 inda M. Arthur 4212 ourt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Garnson Vaugho C. Greade Funeral SVCO 21. Signature of Funeral Service Licenses Randalktown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 3□ 1 □ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only onle Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 | Yes 2 | 1 | N 2 DER/Outpatient 3 □ DOA Certification: To 1 Inpatient After this 27. M. nn of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes n 24 hours after death.

The Funeral Director: A pletely filled in by the 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 rettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and 00062610 30. Name and address of person who completed cause of geath (Item 23a) (Type, Punt) 5401 Old court Canveer CiAiBI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 35852 For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 27 2009 **Physician** OCTOBER 12:56 A M FRIEDA BL UM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL DOVE HOUSE WESTMINSTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 09/19/1924 Funeral 1 □ M 2 X F 85 219-22-4775 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, tre Predical Examinar must be notified at 1 ☐ Yes 2 No Director MD CARROLL **ELDERSBURG** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 1060 CAREN DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2/☐ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene, other than " Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed witl Department of Health and Mental Hygient Important: If Item 27 Is marked other the any liqury or other traumatic event, ITE 1000. HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOLDFINGER MARY SHERMAN ၉ 19a. Informant's Name/Relationship (Type. Print) ROBBYN KRAMER/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1060 CAREN DRIVE, ELDERSBURG, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State RIGA KURLANDER VEREIN 10/30/2009 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Loc 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ilated ischemic Chediomy opathy **Physician** terenc /Medical Due to (or as a consequence of): Examiner SATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 Due to (or as a consequence of): Physician/Medical the attending p for use as t yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 OBSTRUCTIVE polychamy disease 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed sewledementa Alzheinen's 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has I page 2 s MACURE Normai veriegra 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) STSTED COVER Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 10/23/2009 Found: 5:00a.m. 2 Accident Subject fell. 1 ☐ Yes 2X No after death

Director:
d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1060 Caren Drive, Eldersburg, MD 4 ☐ Homicide within 24 hours aft To the Funeral DI completely filled in Home

Division of Vital Hospital or Attending

Baltimore, Maryland 21215-0036

that the death certificate be executed

Box 68760

P.0.

Records,

State Registrar DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of certifier

and manner stated.

48NUR

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

CUPSIMIN STER

manlad

29d. Date signed (Month, Day, Year)

27/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Nov **Physician** 5 4:00 PM Lucille Agnes Bowen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1811 Hampstead Mexico Rd. Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5 (Month, Day, Year) 5 - 1 2 - 1 9 2 0 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. Maryland 1 M 2 X F 219-07-5275 89 **Director** Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location fshow 10a. State 2 should be filed within 72 hours after death with the Marylar n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at Carroll Westminster MD 1 □Yes 2 No Director 10g. Citizen of What Country? 1811 Hampstead Mexico Rd. 10f. Zip Code 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🍎 No Specify. 2 Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Grocery Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other transment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Horan Clyde Arthur Bastin ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1811 Hampstead Mexico Rd., Westminster, MD 19a. Informant's Name/Relationship *(Type. Print)* Kay E. Wagner-daughter 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial 11-9-2009 Sykesville, MD 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home Thomas 254 E. Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 plonths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death
☐ Unknown Day Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 icate has been sig 2 **X**No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 X No 1 ☐Yes 2 No Division of Vital 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2, per MD G898 12/2/09 TT Amend #2, per MD G898 12/2/09 TT State of Maryland / Department of Health and Mental Hygiene State Amend Items 1,4a per dr., g897 11/09/09 the ath Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Iona Louise Banzhoff **Physician** A Louise Banzhoff October 2009 4 . 41 /Medical 4a. Eacility Name (If not institution, give street and number)
16505 Virginia Avenue, Apt B215
Hospice of Washington County 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🖺 F Hours Director 193-18-6231 86 Sept 3, 1923 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Expression must be netflied at MD Williamsport Washington Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. housewife own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Fleming Mabel Leightner ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Banzhoff/daughter 12442 Harvey Road; Clearspring, Maryland 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Ronal d S. Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Maryland 21201 Baltimore, 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Archano **Physician** ENO(/Medical Dué to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.0. the be detached 9 Unknown 9 Unknown ρ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Vital 2 No 1 ☐ Yes 2 🗌 No 1 □Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 2 No 1 Yes Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) of this 28a. Date of Injury (Month, Day, Year) 27. Mariner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat Funeral Director: 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signat 29d. Date signed (Monty, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

who completed cause of death (Item

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 35856 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** unningham entoni 2009 11:150 M October . /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Bon Secour Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 20, 1961 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 M 2 □ F 218-80-2782 47 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Randallstown 1 □Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a or 9602 Mendoza Ave. 21133 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No 1 → Never Married 2 Married altimore, Maryland 21215-0036 Black Completed by If Yes, Give Year or Dates: 1 □ Yes 2 □★o Specify 3 Widowed 4 Divorced "natural" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, in a Medical I once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eby Cunningham Goldie Jackson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Cunningham 2111 Brunt St. Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Cemetery 11/4/09 Dundalk, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wesley Chavis, Jr. FH 2007 Eastern Ave. Baltimore, MD 21231 23a. Part 1. Enter the disease or complications that a shock, or heart failure List only one cause of ea aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acquire **Physician** End Starp Immunode /Medical Due to (or as a consequence of) Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Partyl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 alvi 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? certificate l 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, f. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No. 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 1 🔽 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 105 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Secours Hospital, 2000 West

32. Registrar Signature

Baltimore Street, Bathmore, Maryland, 21293

Medical

icordo Usurno

30.111 me a vi address of person who completed cause of death (Item 23a), (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day FRank Davis 2:01 /Medical IO 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN BALTIMORE MD GOOD HOSPITAL N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 219-40-1543 **XX**M 2□ F Director 66 Mar.17,1943 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov "natural", or Items 23a or 28a-f show MD N/ABaltimore Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Conway St. Apt. 403 21201 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2√No Completed by Specify: Black 3 XWidowed 4 ☐ Divorced Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) es 1 and 2 should be filed wi of Health and Mental Hygien f item 27 Is marked other th 10th Grade Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Davis Mildred Campbell ည 19a. Informant's Name/Relationship (Type. Print)
Michelle Davis/ Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Kenyon Avenue Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If ite
any Injury or ott
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 11/3/09 Baltimore, MD 21. Sign we of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE **Physician** ORGAM SYSTEM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐Yes 2 ☐No 5 Other (specify) by the a 9 Unknown 9 | Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ RENAL DISEASE STAGE 1 Tes 2 No 3 Probably 4 Unknown Completed REMAL (ELL CARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 24a. Was an autopsy performed CIRRHUSIS LIVER 1 ☐ Yes 2 **□** Ńo 1 ☐Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death Director: 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO vanul Sanh 10/31/2009

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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SANJIVANI KOLGE, MO. GOOD SAMARITAN HOSP, STOI LOCH RAVENBLYD, BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 37 November 2000 SHIRLEY RUTH DAVENPORT 4a. Facility Name (If not instituțion, give street and number) 4b. City, Town, or Location of Death 4c. County of Death maryland General LAMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🛛 F MARYLAND 213-52-1922 61 1-9-1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County MD. N/A BALTIMORE 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1112 N. BENTALOU ST. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2X No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12--0-HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES JACKSON SADDIE BOOTH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA DAVENPORT (DAUGHTER) 1112 N. BENTALOU ST. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MT. ZION CEMTERY 11-6-2009 BALTIMORE, MARYLAND D. HIBNER. Name and Address of FacilityREDD FUNERAL SERVICE 21. Signature of Funeral Service Micer see JONATHAM 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ereprovascu Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) d. 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Be Completed

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Funeral

Director

If item 27 Is marked other than "natural", or items 23a or 28a-f show or other treumetic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

Health and Mental em 27 is marked of

Baltimore, Maryland

Examiner physician and s the burial-transit Hospital or Attending Physicien: The law requires that the deeth certificete be executed Physician/Medical for use as attending as been signed by the 2 should be detached ģ Completed has page this certificate Be Certification: To

neral Director: After the filled in by the funeral

completely

24 hours after death Funeral Director: /

within 2. To the I

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Division of Vital Records, P.O. Box 68760,

	l
IF FEMALE: 23b. Was decedent pregnant	
in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	
Part II. Other significant conditi	ons

contributing to death but not resulting in the underlying cause given in Part I.

1 / inpatient

1 □ Yes	2] No	3 ☐ Probab	oly	4 Unknow
24a. Was an		24b.	Were autops	y fin	dings availab

23e. Did tobacco use contribute to the cause of death?

Vas case referred to medical	26. Place of Death

	performed? 1 □ Yes 2 □ N	death?
26. Place of Death (C	Check only one)	
Other: 4 \sum Nursing Home	5 Residence	6 ☐Other (Specify)

prior to co	ompletion of cause of
1 ☐ Yes	2 □No

1 ☐ Yes	2 D No	
7. Manner of	Death	5 □ Pending

☐ Pending investigation	28a. Date of Injury (Month, Day, Yea
Could not be determined	28e. Place of Injury -

28a.	(Month, Day, Year)	Injury	М	Work? 1 □Yes	2 🗆
28e.	Place of Injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, office	

2 ER/Outpatient 3 DOA

28f.	Location (Street and City or Town, State)	d Number or	Rural Route	Number,

29a.	Certifier
	(Check only
	one)

2 Accident

3 Suicide

4 Homicide

11/ CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature	and title of certifier	
	Mahin	1

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29c. License number

29d. Date signed (Month. Dav. Year)

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}.	Name	and	address	of	person	who	com
		1		- 2		-	ľ

ppleted cause of death (Item 23a) (Type, Print)

State Registrar

Medical

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■ Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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	•	State Registrar		Cei	rtificate of l	Death	Reg.	No. 2009	35859
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Barrett	Harold	Dorsey				Day Year	3. Time of Death
Examine		4a. Facility Name (If not institution, give st HOWARD COUNTY GENEI		0	COLUMBIA	r Location of Death		4c. County of Death HOWARD	
Funeral Director		216-17-1115 "	M 2□F 7. Ag	e (In yrs. last birthday) 28 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Coul	place (State or Foreign ntry) MD
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD HOWARD		10c. City, Town or Lo	cation				10d. Inside City Limits 1 □ Yes 2 1 No
with the ? 3a or 28a-	al Director	10e. Street and Number 6587 DOVECOTE DRIVE		COLUMBIA	10f. Zip Code 21044		10g.	Citizen of What Cou	ntry?
	by Funeral		2. Was Decedent Armed Forces? 1 ☐ Yes 2 🕍 I If Yes, Give	No	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 X No	lispanic Origin? (Span, Mexican, Puerto	oecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	etc.
hin 72 hour e. an "natural"	Completed t	15. Decedent's Educa (Specify only highest grade	Year or Dates: ation completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	sing	WH]	
2 should be filed within 72 he and Mental Hygiene. Is marked other than "naturaumatic event, the "natical	Be Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		SALES	SMAN		e (First, Middle, Mai	SEARS den Surname)	
d Men marke	ပ္	RONALD	- 0-1-1	DORSEY		CAROLYN			ANOFF
nd 2 sh ulth an 27 is r r traur		19a. Informant's Name/Relationship (Type RITA BLITZ/GRANDMO	,				134、RANDA	ity or Town, State, Zi	MD 21133
of Hear		20a. Method of Disposition		20b. Place of Dispo		1		c. Location - City or To	
Page ment ant: It		1 🗖 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other <i>(Specify)</i>	moval from State	BETH TFI	LOH CONG.	11-06	6-2009 BA	ALTIMORE,	MD
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evoluce.		21. Signature of Juneral Service Licenses	CHA					& BROTHER	,
Physician /Medical Examiner	l Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Fijury that initiated events resulting in death) Last	Due to (or as	I the death. Do not entine. A C C C C C C C C C C C C C C C C C C	er the mode of dyir	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	nysician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnanc	y		23d. Date of delive	very Day Year
w requires that the de been signed by the should be detached	d by Phys	Part II. Other significant conditions cont	-	ut not resulting in the ui	nderlying cause giv	en in Part I.		co use contribute to	the cause of death?
The law rectate has bee page 2 shou	ompleted	Acute repol foil Rhobdomyolus	we.	francaminit	<u> </u>	ordiony ope	24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ician: T certifica ector, pa	BeC	25. Was case referred to medical examiner?	anital:	70. 20 (1)(1)	1045		th (Check only one)	12100	
hys this	ation: To	1 Yes 2 No	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier ery 28b. Time of lnjury	f 28c. Injur Worl	ry at	ome 5 Residence 28d. Describe how	e 6 Other (Specinjury occurred	<i>fy</i>)
tal or Atters after de at Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
the Hospi nin 24 hou the Funer npletely fill	Medical	(Check only 2 Medical Examination)	cian: To the best er: On the basis of and manner st	of my knowledge, deatl of examination and/or in ated.	vestigation, in my o	ppinion, death occu	rred at the time, date	and place, and due	to the cause(s)
Son With	2	29b. Signature and title of certifier	2	110	29c. Licens	o 66 S1		. Date signed (Month,	
21		30. Name and address of person who con	1	3	Print)				21044
Stat Registra		31. Date filed (Month Day, Year) 200		ar's Signature	ale	0/24 Litt	ie Patuxe	nt Pkwy Co	olumbia, MD
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Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	alth and Mental Hygiene

Douglas Fank		1-For State Registrar Certificate of Death Reg. No. 2009	3586				
Physic	ian/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Abouth Day Year					
Medical Exam	iiner	Douglas Patrick Funk 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death					
<i>.</i>		Johns Hopkins Hospital Baltimore					
Funera Directo		5. Social Security Number 180 – 38 – 7728 6. Sex 1. Age (In yrs. last birthday) 15 Under 1 Year 15 Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Country) 15 Under 1 Year 15 Under 1 Year 15 Under 1 Year 15 Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State Country) 180 – 38 – 7728 180 – 7728	e or Foreign vania				
, w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Limits				
and show s	, i	MD Carroll Finksburg 1 Yes	2 X No				
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 73 is marked other than "natural", or items 23a or 28a-f show invitive or other resumants event, the Medical Examiner must he motified at once.	Director						
death with	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	Black,				
rs after ural", o	by F	3 Widowed 4 Divorced in res, give fear 1 Yes 2 X No specify: Specify: WITI CE					
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)					
0036 vithin iene. er thau	Completed	12 Inspector Engineering					
115-(Be Co						
212 ould be a Ment s mark	10 B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
MD nd 2 sh alth an		Nettie Funk-wife 2716 Sandymount Rd. Finksburg, MD, 2104 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State					
Ore, ges 1 a t of He		1 Burial 2 Cremation 3 Removal from State crematory or other place)	1				
nit Pa artmen		Patapsco Cemetery 11-6-2009 Finksburg, M 21. Signature of Funeral Service Licensees 22. Name and Address of Facility Fletcher Funeral Home					
Dep Dep	`	Thomas D. Flithin 1254 E. Main St., Westminster, MD 211					
Physicial /Medica /xamine	Ī	failure. List only one cause on each line. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease acomplicated by Influenza (HlN1) Viral Infection	mate Interval in Onset and Death				
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b					
	iner	if any, leading to immediate cause. Enter Underlying Cause C. C. Due to (or as a consequence of): C. C.					
nd und	I Examiner	vents resulting in death) Last Due to (or as a consequence of): d.					
760, cate be executed physician and the burial practice.	Medical	X UNPENDED 8 per fh g898 12-15-09 vt 23a,PII,27,perME, g898 1274/09 TT					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and the child in the former forms of the bursel or the former and the control of the control	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year				
O. B. hat the ded by the	l g	L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	of death?				
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The Three of the Control	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route or Town, State)	Number, City				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director	Medical Ce)				
To	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y					
		O.C.M.E. November 4, 2009					
- d		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
<u> </u>	State	Also Parling Change					
	istra	To 31. Date filed (Month, Day Xood)					

		1	For State Registrar		State of Ma	iryland	-	irtment of H tificate of L			іепаі пу	Glen Reg. N	200	9	3586	51
			1. Decedent's Name (First	t, Middle, Las	st)						2. Date of De Month	D	av \	'ear	3. Time of Dea	
	Physicia /Medic	_	Joyce M	i Ga	amble						Nov.	4,	2009		2:20 A	M
	Examin		4a. Facility Name (If not in	nstitution, give	e street and number)			4b. City, Town, or				4	c. County of		2 3	
×1.		Anne Arundel Medical Cen						Annap			O Data of Bi	-th	Anne		Idel	roian
	Funeral Director		5. Social Security Number 210–22–0306		ex 7.Age	81	t birthday) Yrs.	If Under 1 Year Months Days	Hours		8. Date of Bi (Month, D 07/05/	1928	3	Cour PA	atry)	neign
	yland how at		Usual Residence of Decer 10a. State 10b.	County		10c. City,	Town or Lo	cation						1	0d. Inside City L	
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Extininer must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 3 💢 Widowed 4 □ □		12. Was Decedent Armed Forces? 1 □Yes 2♥↑ If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □Yes 2⁄Ω No	Specii		Rican, etc.)			White,		
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p	il Hyg other rent,	Be C	17. Father's Name (First,	Middle, Last,)				18. Mot	ther's Name	e (First, Middle	e, Maide	en Surname)		
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ary	short and harisman	1	19a. Informant's Name/R		Type. Print)			ng Address (Street						tate, Zip	Code)	
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altimore, Maryland	Pages 1 ment of H ant: If iter		20a. Method of Disposition 1 ☐ Burial 2X Cre 4 ☐ Donation 5 ☐ 0	emation 3	Removal from State		antic	osition (Name of matory or other place Cremator	У	11/09	9/2009	Gl	en Bur	nie		
Balt	permit. Depart Import any inj		21. Signature of Fune al	Service Lice	T. Ha	rman		2. Name and Addre 337 North			shton F ., Eas				2	
			23a, Part 1. Enter the dis	sease, or com	plications that caused	the death.			-	_			60		Approximate Interval Between	
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/ita	Physician: The this certificate al director, pag	Be (25. Was case referred to examiner?	medical	Liital			Ott	201		th (Check only					
of \	ys .S. Ys		1 Yes 2 No		- Acces		R/Outpatie	ent 3 LI DOA	4 🗆	Nursing H	ome 5 ☐ Re 28d. Describ				eify)	
	ding F	ion		Pending investigation	28a. Date of Inj (Month, D		Injury	Wor	rk?]Yes 2	□No	200. 2000112	01101111	ijary oooa			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, to completely filled in by the funeral director, to	Certification: To	2 Accident 3 Suicide 6 [4 Homicide	Could not be determined		jury - At hon tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office			28f. Location City or 7			er or Ru	ral Route Numbe	er,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only 2 one)	Certifying P Medical Exa	Physician: To the bes aminer: On the basis and manner s	of examinati	rledge, dea on and/or i	th occurred at the t nvestigation, in my	ime, date opinion,	e and place death occu	e, and due to t irred at the tim	he caus ie, date	e(s) and ma and place, a	nner as and due	stated. to the cause(s)	
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Please Type of Print in Black Indelible ink 1 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 2009 Physician GREEN ABIAN EE october /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner GROUP HOME CATONSVILLE MID-ATLANTIC BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**X**M 2□F Days Months Hours Min. 219-08-9224 Director 07/25/1985 MARYLAND Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No TONSUILLE by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or "natural", or items 23a or 21228 U.S.A. 500 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nichols ပ ElizAbeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES ST. APTIGO BALTIMORE, MARYLAND 524 N. GRANDMOTHER JOAN BROOKS Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **BrookLyn Park** 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10 2009 GIEN BURNIE, MARYLAND HOLY CROSS CLEME 22. Name and Address of Facility The DERRICK C. JONES FIH, P.A. 21. Signature of Funeral Service License 4611 PARK HGTS. AVE., BALTIMORE, MARYLAND ZIZIS 23a. Part 1. Enter the disease, or complications to trace caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 415 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) as a consequence of) Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) P.0. I ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 6 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **8** No 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) scisted h Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: completely filled in by the 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier ee Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (nem 23a) 10/1

DHMH 17 Rev 1/2001

State Registrar 32. Registra

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35863 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician Nov 5 3:43 PM James Melvin Gill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Golden Living Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5 - 24 - 1936 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Maryland 1 XM 2 □ F 73 Yrs 215-32-9205 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment, ust be putified at once. Westminster 1 ☐ Yes 2 No MD Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Timber Ridge Dr. 21157 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify <u>۾</u> 3 Widowed 4 N Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Distributing Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Gill Yingling Ida ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 20 Charlestown Ct. Littlestown, PA 17340 Bob Muse-nephew Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buria! 2 🖾 Cremation 3 ☐ Removal from State South Carroll Crem 11-7-09 Winfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Lice 254 E. Main St., Westminster, MD 21157 7. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 months Metastatic Pancreatic Cancer disease or conditic resulting in death) / /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 XXNo 1 ☐ Yes 2 🖾 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 **X**o 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After Injury 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D25443 11/6/2009 H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John W. Middleton 688 Poole Rd. Westminster, MD 21157 31. Date filed (Month, Day, Year NOV 0 9 2009 32. Registraris Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a,25, per me,g897.11/06/09dhb.

Reg. No. 2009 35864 1. Decedent's Name (First, Middle, Last) 2. Date of Death Etope 29 av **Physician** 7:13AM HENRIETTA EVERSLEY HESTICK /Medical 4a. Facility Name (If not institution, give street and number) 4b Sity, Town, or Location of Death 4c. County of Death Examiner Hospital o Hmore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2KCKF 5, 66 Director MAR 1943 **GUYANA** 218-64-0752 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2\\ No Director BALTIMORE MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò II.S.A. 3311 RIPPLE RD. 21244 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 XX Married ō 1 ☐ Yes 2 🔀 No Specify þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE PRACTICE PSYCHOLOGIST 6+ yrs 12yrs 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be f Health and Menta Item 27 is marked REV. SARAH EVERSLEY ျှ WALTER EUSTACE EVERSLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Ripple Rd., Windsor Mill, Maryland 21244 Gersham Hestick/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Department of h Important: If ite any injury or of once. 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 11-07-09 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUST MEMORIAL permit. 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE 21. Signature of Funeral Service Lig Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mracrania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consectioned of) Examiner the death certificate be executed attending physician and Due to (or as a consequence of) CERTIFICAT 68760, Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent precoant in the past 12 months? 3 🗆 Ectopic pregnancy Day Year 5 Other (specify) 1∐Yes 2⊠No signed by the 9 Unknown ۵. The law requires that 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 No 1 ☐ Yes Vital Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D00666-14 enge Billy October 29,2009

Registrar

State

31. Date filed (Month, Day,

おがれ

E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tennifer Berkeley, MD Sinai Hospital of Baltimore

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #15, per Fh g897 11/9/09 TT
State of Maryland / Department of Health and Mental Hygiene 2000 35865 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ Silas Hurt, Jr. lavent 200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hosp. (ER) Baltimore n/a 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Country) 26 Director 5911 80 192 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland at Director r 28a-f sh notified a 1√L Yes 2 □ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be I Funeral 424 E. 23rd St. 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 1951-53 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th laborer Bethlehem Steel Co. 1911 it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygie rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Silas Hurt, Cornelia Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Hurt (daughter) 424 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Ε. 23rd Balto, Md. 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal Green Mount Crematory Baltimore, Md 4 ☐ Øonation 5 ☐ Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home ature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final §hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner yrs Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4 Pregnant a Month Pregnant at time of death 5 ☐ Other (specify) 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown "Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Yes 2 No certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 Hospital 70 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 atural injury 1 Yes Accident 2 🗆 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) airl omava D5201 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) 650 Baltimore E an + Jane 6 31. Date filed (Month) istrar's Signature arkel State Registrar

			Please	Type or Print in Black Indelible Ink. Ensure Al amend item 8 per fh g897 11-9-09 v State of Maryland 7 Department of Health and M	IL Copies Are Legible.	
			1 - State Registrar	Certificate of Death	Reg. N2 0 0 9	35866
	Physici		1. Decedent's Name (First, Middle)	AFALE JOIES	2. Date of Death Month Day Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If fot institution, g	ive street and number) 4b. City, Town, or Location of Death	4c. County of De	ath
414	Funeral		5. Social Security Number 6.	Administration of the second s	8. Date of Birth (Month, Day, Year) 1955 9. B	irthplace (State or Foreign
12.	Director	į	Usual Residence of Decedent	12/M 2 F 54 Yrs. Months Days Hours Min.	June 25, 1954	MARYLAND
	faryland show ed at	ō	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the N or 28a-f e notifi	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
	leath wi	Funeral I	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Culpan, Mexican, Puerto	pecify Yes or No- 14. Race - Afr	erican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married	Armed Forces? 1	Rićan, etc.) Black, Wh Specify:	ite, etc.
21215-0036	72 hour natural' lical Ex		15. Decedent's (Specify only highest g	Education 16a. Decedent's Usual Occupation	16b. Kind of Busines	s/Industry
2121	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Computer Jechn	iciAN BAHD	G+E
bug	be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, La.		e (First, Middle, Maiden Surname)	
Maryland	should be and Mental s marked o	은	19a. Informant's Name/Relationship	(Type, Print) 19b. Mailing Address (Street and Number or Rur		ES Zip Code)
	1 and 2 Health a em 27 Is ther trait		BARDARA J.A. 20a. Method of Disposition	ckson 902 M Hord MI	Date 20c, Location - City of	or Town, State
altimore,	Pages nent of ant: If It		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State cemetery, crematory or other place)	12009 BAHO.	M
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Lic		NES, JR FUNER	AL SK
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. Do not enter the mode of dying, such as cardiac by one cause on each line.	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):		Onset and Death
	Examiner		Sequentially list conditions,	b		•
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events	Due to (or as a consequence of):		
.09	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence of):		
687	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	d		
Вох	eath ce attendii for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
P.0.	nat the d d by the etached	Physi	1 Yes 2 No 9 Unknown	9□Unknown	and Biddelines and Allines	
	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	ro the cause of death? Probably 4 Unknown
Division or Vital Records,	ne law rec has bee ye 2 shoo	Completed			autopsy prior to	autopsy findings available completion of cause of
ital		Be Cor	25. Was case referred to medical	26. Place of Deat	performed? death 1 Yes 2 No 1 Yes th (Check only one)	es 2 No
or V	is din	2	examiner? 1 Yes 2 No 27. Manner of Death		ome 5 Residence 6 Other (Sp. 28d. Describe how injury occurred	necify)
sion	Attending Ph death. ctor: After th y the funeral	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(<i>Month, Day Year</i>) Injury Work?" on M 1 ☐ Yes 2 ☐ No	200. Describe now injury occurred	
Divis	after de Directe d in by t	ertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier Check only one) Certifying I	Physician: To the best of my knowledge, death occurred at the time, date and place, aminer: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner rred at the time, date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated. 29c. License number	29d. Date signed (Mo	nth, Day, Year)
	Λ		20 Name and address of a second	MD 051767	11/6/	2007
	2 √		Gregory M	o completed cause of death (Item 23a) (Type, Print) 600 N. Wolf 1. Lucas. MD Baltinove	MA Z128	7
*	Sta Registr	- 1	31. Date filed (Month, Jay, Year)	32. Bootstrar's Signature		
DH	MH 17 Rev 1/2	001	1101 008	J. Harris		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>009</u> Physician/ 11:00A M Anna Eugenia Jones Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FutureCare/Sandtown-Winchester Baltimore N/A . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth 6. Sex **Funeral** 1 🗆 M 2X 🗆 I Days Hours (Month, Day, Year) 87 Director 215-28-7722 Virginia Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c, City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5125 Arbutus Avenue 21215 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates mit. Page 1 and 2 should be filed within 72 hours bartment of Health and Mental Hygiene. octant: If item 27 is marked other than "naturinjury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) Dyett Funeral Home College (1-4 or 5+) Receptionist 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walon Johnson Mary Willie Buchman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Carney/ Grandson 1515 E. 35th Street Baltimore, Maryland21218 Baltimore, 20a. Method of Disposition Department of F Important: If ite any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/09 Baltimore, Maryland Greenmount Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature 5240 Reisterstown Rd Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on with line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Exami or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 been signed by the attending p should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacce use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 tate of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O3 **Physician** 10 2009 7:40p M J. Kiah Cammille /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 214-38-4668 07 MD Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Y□Yes 2□No Director NA Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21217 U.S.A. 301 McMechen Street Apt 205 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify ģ Specify: White 3 Widowed W Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Duty 6th grade na Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Cole ပ John LeBon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2805 Majesty Lane, Edgewood, Md 21040 Jacqueline Harris-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If It any injury or c once, X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 10/10/09 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lib nsee March F/H West 23a. Part 1. Ether the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cose (Final disease or condition) 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death Due to (or as a consequence of) 22 4RS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year

Physician /Medical Examiner

and

ned by

has

this certificate

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Completed

Be

Certification: To

Medical

ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at

n and Mental Hygiene.

Pages 1 and 2 should be f nent of Health and Mental

Health em 27 i

the Maryland

72 hours after death with

Maryland 21215-0036

Baltimore,

68760

Box

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Record

Division of Vital

The law requires that the death certificate be

Physician:

or Attending

after death

within 24 hours a

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes	2 ☐ No	3 Probably	4 🗌 Unknown
18/00 00	0.46	More autonou fi	ndinas availabla

Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 1 ☐Yes 2 ☐ No 1 ☐ Yes

25. Was ca	ase referre	d to m	edical
examir 1 X Ye	er? s 2 1	fo	
_			

1 ☐ Yes 2 No

9 Unknown

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 🗌 Suicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 09/28/2009 7:30 a 28c. Injury at Work? 1 ☐ Yes 2 X No

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 28d. Describe how injury occurred

Subject fell while being transferred from bed to chair

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town State) McMechen Street, Apt. 205, Baltimore, MD determined Home

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

1 Inpatient 2 ER/Outpatient 3 DOA

70 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

828 EVTAL HOROWITZ MARRET

Hospital:

31. Date filed (Month, Day, Year) State 6

4 Homicide

29a, Certifier

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mon 200 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dowson Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Hours Country) Yrs. Director 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified $\mathcal{M}\mathcal{D}$ 1 Yes 2 No town Baltimore 10f. Zip Code 0 10e. Street and Num 10g. Citizen of What Country? Examiner must be 23a 21133 Funeral USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Dece ent Ever in U.S 1. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 5 ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse F oreman 15 Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MONc1 and 2 should by Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Owings Milk, MD 3-2009 forest 4 ☐ Donation 5 ☐ Other (Specify) in C. Greenettineral Stys. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ndalls-town, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter Interval Between Onset and Death Immediate Cause (Final disease or condition Sa wagea Concer Pmysician/ untris Medical Due to (or as a con-quence of): resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🎞 Probably 4 ☐ Unknown Records, been signated by the second of 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No this certificate of Vital 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 D Other (Specify) NOSOC Q ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending Division 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 29a. Certifier

within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNSON HALVES AAMON M 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2000 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08331 State of Maryland / Department of Health and Mental Hygiene Joshua McKinney 2009 35870 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 26, 2009 2215 hrs Joshua D. McKinney Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 214-11-7368 Director Country) 1x M 2 F 23 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Auv 1 XYes 2 No MD Baltimore e notified at once. 28a-f show Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21214 2804 E. Cold Spring Lane 14 Race - American Indian Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married Married Yes Specify: Black 5 Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after:
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Department of Health and Mental.

Department of the Mental o If Yes. Give Year Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Disable Disable 12 18 Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Gwendolyn Wiggins Edward McKinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cold Spring Ln. Baltimore, MD 21214 Gwendolyn Wiggins 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Carmel Cemetery 11/6/09 Dundalk, MD Mt. Donation 5 Other Specify 22. Name and Address of Facility Wesley Chavis, Jr. 21. Signature of Juneral Service Licensee 2007 Eastern Ave. Baltimore, MD 21231 Approximate Interval the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Physician Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and hysician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the buria Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ☶ Yes 2 ✔ No 3 Probably 4 Unknown þ Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No ✔ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 V Yes Nο 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Certification: Oct 24, 2009 2206 hrs Natural 1 Yes 2 ✔ No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 or Town, State) 2000 N. Wolfe Street, Baltimore, MD Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 29, 2009 O.C.M.E. 180 30. Name and address of person who completed cause of death (Item 23a) 4 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 31. Date filed (Month, Day Year 32. Registrar's Signati State NOV 09

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** McLaughlin, Sr. Donald 000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner autimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 03/17/1946 **Funeral** Hours Months 1**X** M 2 □ F Days 63 218-42-9906 MDDirector Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Examinating and Injury or other traumatic event, its Medical Examinating and Injury or other traumatic event, its Medical Examinations. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Director MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5652 Braxfield Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 Ϊ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Charles McLaughlin Yother Josie Kate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katie McLaughlin, Wife 5652 Braxfield Road, Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Atlantic Crematory 11/10/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Skarda Funeral Home, PA T. Harman 2829 Hudson Street, Baltimore, MD 21224 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be exect Due to (or as a consequence of) Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 🗌 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 the Hospital or Attending Physician: The 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Date of Injury (Month, Day, Year) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deat 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier ical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 9 2009

P.O. Box 68760

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD G897 11/9/09 TT

amend #5&23e Per Manyland Hyperstructure (Property of Lyperstructure)

amend #5&23e Per Manyland Hyperstructure (Property of Lyperstructure) For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ICHOEMBE Day Year Demetra Metalios 8:25P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center TOWSON Bal t imore 5. Social Security Number **220–20–700** 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min. 04-15-1927 ear Director 87 New York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo!" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11311 Notchcliff Road 21057 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: U.S.A. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gust Parthemos Margarita Papapetrou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mr. Vaio Metalios - Son</u> Parkville, Maryland 21234 7629 Perring Terrece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗔 Other (Specify) Greek Orthodox Cemetery 11-4-2009 Baltimore, Maryland Signatu Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death HOURS Physician disease or condition resulting in death) HEMORRHAGIC CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of): [/]Examiner Sequentially list conditions, Examiner if any, leading to infriediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year by the 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should b 2XXNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending work? 1 ☐ Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 25886 November 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEBAL OSLER DRIVE. TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, g897,11/09/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Edward Neale 2009 5:45 Charles РΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care - North Point Dundalk Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Birthplace (State or Foreign Country)
 New York 8. Date of Birth (Month, Day, Year)
March 17,1911 1 🔯 M 2 🗆 F Days Hours Director 217-03-0363 98 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified Baltimore Md. Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Lodge Farm Road Apt. 108 21219 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: White 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic 4 years Service Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennet Holmes Neale Elizabeth Harriet Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Sutherland Daughter 7222 Kimmel Ave. Dundalk, Maryland 21222 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of October 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bay View Crematory Baltimore City, Md 28, 2009 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ a Hypertensing Atheroscherchic Conchorusculum Diseco disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Hence death? certificate 2 - N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 🖾 Yes 2 🐼 No Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 09/22/2009 8:00 a. M 2 **X** No Subject fell. Accident Investigation 1 Yes ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2825 Lodge Farm Rd. Apt. 108, Edgemere, MD determined Home edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifyin. Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and the to the cause(s) and manner stated Certifyin. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eseit Dut 239lelec

Registrar

State

32. Registrar's Signature

Point Rd. heltimore MD ZIZIG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-Dart

31. Date filed (Month, Day, Year)

9-08162 Daniel Ugochukwu N	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wachukwu State of Maryland / Department of Health and Mental Hygiene 2000 250
1 R	wachukwu State of Maryland / Department of Health and Mental Hygiene 209358 - For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death 3. Time of Death
Medical Examiner	Daniel Ugochukwu Nwachukwu October 21, 2009 Year O857 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Johns Hopkins Hospital Baltimore
Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or North) 1 X M 2 F 52 Yrs. Months Days Hours Min. 12-6-1956 Country igeria
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 M
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 3 K Eddy Stones Place 10f. Zip Code 21221 NIGERIA
ath with items 23 set be no ineral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 X No
urs after (tural", o	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Speci
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Master's Cab Driver Diamond Cab
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medics Be Comple	17. Father's Name (First, Middle, Last) Samuel Nwachukwu, Sr 18. Mother's Name (First, Middle, Maiden Surname) Irene Oroni
MD 212 d 2 should b lth and Ment in 27 is marl aumatic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Nwachkwu, Jr-brother 48 Solar Circle Apt N Balto, MD 21234
and lealt fran	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Removal from State
Baltin permit P Departmet Importan injury or	4 Donation 5 Other Specify: 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 122. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, Md 21202
Medical `xaminer Jau	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts resulting in death). Last
and and	events resulting in death) Last Due to (or as a consequence or). d. UNPENDED AMENDED
ox 687/ ath certifics attending pl or use as th	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1
P.O.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ling Physician: The law requirer After this certificate has been signeral director, page 2 should be on: To Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
	25. Was case referred to medical examiner?
Ing Pl	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury at Work? 1 Ves 2 No 28d. Describe how injury occurred
∑ કર્લ ≒ાં ≔ા	3 Suicide 6 Could not be determined Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Vithin To the Comple	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
Σ	Carol Hallan O.C.M.E. October 22, 2009
İ	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 35875

	1- For State Cer	rtificate of Death	Reg. No.
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of D Month Novemb	per 3, 2009 Year 1013 hrs
	Aa. Facility Name (if not institution, give street and number) 1569 Abbotston Street	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Aaryland 28a-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City MD 10c. City	10d. Inside City Limits 1 XYes 2 No	
the Maryland a or 28a-f sh ptified at once	616 N. Clinton St.	10f. Zip Code 21224	10g. Citizen of What Country? USA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced Characteristics of the control of the contro	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify:	White, etc. Specify: Black
y, MD 21215-0036 and 2 should be filed within 72 hours afte tealth and Mental Hygiene team 27 is marked other than "natural", traumatic event, the Medical Examines To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder	16b. Kind of Business/Industry Private
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica To Be Comple	Willis Parker, Sr.	18.Mother's Name (First, Middl Virginia Mea	idows
MD 21 d 2 should tht and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Willis E. Parker III	19b. Mailing Address (Street and Number or Rural Route N 1618 N. Milton Ave. Bal	timore,MD 21213
MOFE Pages sent of Fi int: If i	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Place of Disposition (Name of cemetery, crematory or other place) Clent Crematory 11/8/09	20c. Location - City or Town, State Hanover, MD
	21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease or complications that cause one death	22. Name and Address of Facility Wesley 2007 Eastern Ave. Ba	ltimore,MD 21231
Physician /Medical Examiner	failure. List only cause on each line.	ic cardiovascular disease	Between Onset and Death
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Coude	of):	
ecuted and transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.		
760, icate be executed the burial - transit	IF FEMALE: 23c. If yes, outcome of preg		23d. Date of delivery
Box 687 death certific the attending of for use as t hysician/	23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3 Ectopic pregnancy eath 5 Other (Specify)	Month Day Year
s, P.O. Bo	Part II. Other significant conditions contributing to death but not	,	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown
cords aw requ nas been 2 should		pe	as an topsy indings available prior to completion of cause of death? 1 Ves 2 No 1 Ves 2 No
Vital Rec ysician: The l his certificate I director, page o Be Com	25. Was case referred to medical examiner?	26.Place of Death (Check only one) ER/Outpatient 3 DOA Other4 Nursing Home 5	
of Viling Physic In After this funeral dir	1 Yes 2 No 1 Inpatient 2	, , , , ,	Residence 6 Other: Scene
ion of tending Pl eath. ior: After the funera	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	
Division or spital or Attending hours after death. In erral Director: After y filled in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At h		n (Street and Number or Rural Route Number, City n, State)
To the Hospital within 24 hours. To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination a and manner stated.	dge, death occurred at the time, date and place, and due to the cand/or investigation, in my opinion, death occurred at the time, date of the control of the candidate of the time, date of the control of the candidate of the control of the candidate of the candidate of the control of the candidate of the control of the candidate	ate and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) November 4, 2009
6	30. Name and address of person who completed cause of death (Iter Ana Rubio MD. Assistant Medical Examiner		
State Registrar	31. Date filed (Month, Day York) 32. Registrar's Signat		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** N Month Angelina D. Rampolla 1:35 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Longview Nursing Home Manchester | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Months | Days | Min. | Months | Days | Min. | Months | Days | Min. | Months | Days | Min. | Months | Days | Min. | Months | Days | Min. | Months | Days | Min. | Months | Min. | Months | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Mi 5. Social Security Number 212–18–0258 7. Age (In yrs. last birthday) 97 Yrs 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F MaryTand Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🕅 No Director Maryland Baltimore Glyndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21071 U.S.A. 313 Railroad Ave. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23, any injury or other traumatic event, the Medical Exam. The market Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Tailor Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent D'Amore Paclina Russo မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Railroad Ave. Glyndon, MD. 21071 Paulyne Piccirilli - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Redeemer Cem. Nov. 10,2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD. 21115 21. Signature of Funeral Service Licensee . Hat alle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death n each line Immediate Cause (Final **Physician** disease or condition resulting in death) Zuker /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter think-thing Cause (Disease or injury that initiated events resulting in death) Last Examiner ng physician and as the burial-transit O. Box 68760, Physician/Medical the attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 6 Date filed (Month, Day, Year) State Registrar

ME IOKTOLINE

		For State	State of Ma	ıryland	d / Depa <i>Cer</i>	irtment of He tificate of De	ealth and N e <i>ath</i>	ental Hyg/ ۔	iene 2 C	109	35877
Dhusisis	,	Registrar 1. Decedent's Name (First, Middle, Las				inicate or be	Juli 7	2. Date of Dea	th		3. Time of Death
Physicia Medic	al	MARK ROSS						NOVEMI		2009	3:40a M
Examin	er	4a. Facility Name (if not institution, give GILCHRIST NURS				4b. City, Town, or L. TOWSON	ocation of Death			y of Death TIMOR	E
Funeral Director		5. Social Security Number 6. S	7. Age		st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4-30-19	Year)	9. Birthp	lace (State or Foreign
		214-88-5653 Usual Residence of Decedent		44				4-30-1	903	MAK	I LAND
iryland a-f sho ied at	ctor	10a. State 10b. County			Town or Loc					1	0d. Inside City Limits 1 Yes 2 No
or 28a	Pig	MD N/A 10e. Street and Number		F	BALTIM	ORE 10f. Zip Code			10g. Citizen of	What Coun	
is 23a nust b	Funeral Director	1664 CLIFTVIEW	AVE.			21213			USA		
DEJILIMOFE, IMERYISING Z.I.Z.I.D-UU.30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Zr is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at once.	Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XX If Yes, Give Year or Dates.		If	/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 【XNo	Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - America ack, White, e y: BLAC	etc.
72 hou	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give k	ent's Usual Occupati ind of work done dur		ing	16b. Kind of 8	Business Ind	lustry
within giene.		Elementary/Seconday (0-12) -12-	College (1-4 or 5+ -2-	-}	ENGI	NOT use retired) NEER			ELECT	RICAL	
and be filed antal Hy ced oth	To Be	17. Father's Name (First, Middle, Last)			_	1	8. Mother's Nam		Maiden Surnan	ne)	
arylig bould b nd Mer mark martic		JAMES F. ROSS 19a. Informant's Name/Relationship (7)	/pe, Print)		19h Mailin	g Address (Street and	SUSIE		City or Town	State Zin C	(ade)
e, MG and 2 sh Health a tem 27 is		GARY ROSS (BROT				FORRESTE					
altimore mit. Page 1 ar martment of H portant: If iter y injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othe (Specif		KINC	metery, crem	sition (Name of atory or other place) RIAL PARK	11-9	-2009 I		RE, M	ARYLAND
Deart permit Depart Import any inj		21. Signatur Francisco Service Licens	WALTHAN THAN	D. HI	10.1	Name and Address 721–27 N.					, P.A. LAND 21217
Physician/ Medical		23a. Part . Enter the disease, or composite k or heart failure. List only of Immedit to Cause (Final disease of condition resulting in death)	ne cause on each line. a. Malc	b.	reast	r the mode of dying,		or respiratory arre	est,		Approximate Interval Between Onset and Death
Examiner			Due to (or as a	conseque	ence of):						
red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury	Due to (or as a	conseque	ence of):						
sate be executed physician and the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):						
ertificate ding phy se as the		IF FEMALE:	<u> </u>								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afor 4death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 1 9 Unknown	☐ Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				ate of delive onth	ry Day Year
do, T.O quires that t en signed b ould be deta	2	Part II. Other significant conditions co	ontributing to death bu	t not resul	ting in the ur	derlying cause giver	n in Part I.				e cause of death?
with mecolus, hysician: The law requires in certificate has been significate to; page 2 should be in control.	Completed								sy	Were autop prior to con death? 1 Yes	sy findings available npletion of cause of
/sician: s certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 E	R/Outpatient	Othor	e of Death <i>(Check</i> 4 Nursing Ho			or (Coosife)	hospile
nding Phy ath. r: After this e funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	2	28b. Time of injury	28c. Injury a work?		28d. Describe ho	7		
al or Attendii s after death. In Director: Attendial Director: Attendial Director.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At hom (Specify)	ne, farm, stre	et, factory, office		28f. Location (St. City or Town		per or Rural i	Route Number,
the Hospi nin 24 hour the Funera ipleted filk	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	ician: To the best of m ner: On the basis of exa e Practioner: To the b	mination a	and/or investi	gation, in my opinion,	death occurred at	the time, date an	d place, and du	e to the cau	se(s) and manner stated.
To with		29b. Signature and title of certifier	~			29c License no	8303		9d, Date signe		*
3		30. Name and address of person who c	RIFES MO	670	IN.	Charle	ST	DEMICON	m		
Stat Registra		31. Date filed (100 0 9 2009	32. Registrar	s Signatur	face						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	orato or many	Cer	tificate of E	Death	Reg.	No. 200	9 35878
	Physici /Medi		1. Decedent's Name (First, Middle, La Kedah	ast)	Sutto			2. Date of Death Month	5 200°	3. Time of Death
	Examir	ner	4a Facility Name (If not institution, gi	Medical C	enter	4b. City, Town, or I	more		4c. County of D	eath
	Funeral Director			Sex 7. Age (M	n yrs. last birthday) 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Ye)	9. 931	Birthplace (State or Foreign Country) MD
	show		10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
	e Mai	Director	VA	n/a	Virgini	a Beach				1 X Yes 2 □ No
	with the		10e. Street and Number			10f. Zip Code	63.40	10g.	Citizen of What	Country?
	ms 23	Funeral	981 Donation 11. Marital Status	12. Was Decedent Ever	r in U.S. 13. V	23455-		ifv Yes or No-	U S A	merican Indian.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, ith "Madical Examinar must be multihed at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	If	Yes, specify Cuban □Yes 2 ½ No	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	can, etc.)	Black, W	
15-	n 72 h "natu Indica	Completed	15. Decedent's E (Specify only highest gr		16a. Deced	ent's Usual Occupation of work done du	tion uring most of working	16b	. Kind of Busine	ss/Industry Stainless
212	d withi	mo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) N/A		teel Mil			Stee	_
pu	al Hygi I other	Be C	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name (
Уlа	should be filed within and Mental Hygiene. marked other than imatic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event, the matic event	ဥ	Kedah Tyrone				Irene W			
	nd 2 salth all		19a. Informant's Name/Relationship (Dorothy L. Su	tton-Wife			nd Number or Rural n Drive	Route Number, Cit Virgini	ty or Town, State a Beac	h, VA 61485
Baltimore,	Pages ent of nt: If ii		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Thomsvar nom State	20b. Place of Dispos cemetery, crem Crownsv	ition (Name of atory or other place) ille Vet	Dat 11-10	- 1	Location - City Crowns	or Town, State Ville, MD
Balt	permit. P Departm Importar any injur		21. Signature of Funeral Service Lice	Wane	22.	Name and Address	of Facility Ma: North	rch Éas Avenue	-	, MD 21202
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.	death. Do not ente	r the mode of dying,	, such as cardiac or I	respiratory arrest,		Approximate Interval Between Onset and Death Week
4	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):					
	suted of d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Exert Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co.	nsequence of):					
68760,	ertificate be executed ing physician and as the burial-transit	Medical Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P.	quires that n signed b	þ	Part II. Other significant conditions o	ontributing to death but no	t resulting in the und	lerlying cause given	in Part I.			to the cause of death?
of Vital Records,	e law requir has been s je 2 should i	Completed		*				24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
a	n: Th ficate or, pag		05 Wes see a few day of the last					performed? 1 ☐ Yes 2 🗹	death 1 ☐ Y	? es 2 No
5	Physician: The la r this certificate had ral director, page 2	<u>m</u>	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 EB/Outpotions	Othory	26. Place of Death (C			
υo	ding Phy h. After thi funeral o	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Yea	2 ER/Outpatient 28b. Time of	28c. Injury a Work?	4 LI Nursing Home	5 L Residence 1. Describe how inj		pecify)
Siol	or Attending after death. Director: After in by the fune	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ar) Injury		s 2 🗆 No			
Division	ital or Attend us after death ral Director; lled in by the f	Certification: To	4 Homicide determined	building, etc. (Si	pecify)			City or Town, Sta	nte)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in E	Medical	29a. Certifier 1	ysician: To the best of my niner: On the basis of exa and manner stated.	/ knowledge, death omination and/or inve	occurred at the time stigation, in my opin	, date and place, and nion, death occurred	d due to the cause at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
	Voit Con	≥	29b. Signature and title of certifier	sclance of		29c. License n	_		Date signed (Mo.	
1		3	ter and it is	completed cause of death	(Item 23a) (Type, Pr	int) GREENE.	981 Street E	Baltinoe	e MD 2	<u>'</u>
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	, - , - , - , - , - , - , - , - , - , -				

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Luther Edward Saddler, Jr. 2. Date of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Year)
May 26,1938 If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 216-34-3621 Months Days Hours MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 XYes 2 ☐ No 10e. Street and Number 6112 Edlynn Road 10f. Zip Code 10g. Citizen of What Country? 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Self-Employed 17 Father's Name (First, Middle, Last) Luther E. Saddler, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Saddler 6112 Edlynn Rd. Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery 11/11/07 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Funeral Service Licensee 2007 Eastern Ave. Baltimore, MD 2123 23a. Part 1. Enter the disease or shock, or heart failure List r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 | Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ∐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and P.O. Box 68760, Physician/Medical

Physician /Medical

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the McJicwl Examination of the different

is marked other

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

Baltimore, Maryland 21215-0036

by Funeral

Completed

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cate has been signed by the attending physician page 2 should be detached for use as the buria certificate

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Completed

Be

Medical Certification: To

2 Accident 3 Suicide

4 ☐ Homicide

29b. Signature and trile of certifier

29a. Certifier

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records,

To the

State Registrar 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 ☐ Yes 2 ☐ No

November 5, 2009 Raver Bonlevare Beltimore, Maryland

31. Date filed (Month, Day, Year) NOV 0 9 2009

6 □Could not be

5601 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Loch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ad. 201PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛂 Months Days Hours Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at 10d. Inside City-Limits Director 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **2**3a 15A 212 nul items 72 hours after death v Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban Mexican, Puerto Rican, etc.) 0 1 Newer Married 2 Married Black, White, etc. Completed by 1 ☐ Yes : If Yes, Give 2 **N**No Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Department of Health and Mertal Hygiene. Important if item 27 is marked other than "natural", any injury of other traumatic event. 3 ₩Widowed 4 □ Divorced Year or Dates ac 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname ပ္ 19a. loformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City er Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 s 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State remetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) permit. I Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pitysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 WNo
9 Unknown 3 Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year a 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 **N**0 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 □ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniurv 2 🗆 No Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Mocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200° **Physician** Spence 135A M mille /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UMMS Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🗗 F 218-26-876 Usual Residence of Decedent 8 **Director** should be filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at altimore 1₽Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Completed by 3 Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Spring Groves. 110-411C 104 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be -in Kfor ohr.son ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heatth and Important: If Item 27 is n any injury or other traun once. Denise S ,38 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State OwingsMills, MD 11-13-2009 4 ☐ Donation 5 ☐ Other (Specify) C. Green gunsial SID. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Immediate Cause (Final Se **Physician** DSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No 1 □ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗶 DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date şigned (Month, Day, Year) 000054947 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kat herine brundmann Balt-more ND 21201 32. Registrar's lignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Barbara Ann Singletary 0825 M 200 Wember Seasons Hospice @Northwest Hospital Randallstown 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace | Omitor 1 Year | 194 | 2 | Mary land | 194 | 194 | 195 | 194 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 | 195 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 214-40-9209 1 □ M 2X F 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Baltimore N/A1 XYes 2 ☐ No Maryland 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 4821 Beaufort Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specholack 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Clerical Year 18. Mother's Name (First, Middle, Maiden Surname) Annie K. Part Low 17. Father's Name (First, Middle, Last) Maxie Robinson 19a. Informant's Name/Relationship (Type. Print) 19a. Husband 194 Mailing Address (Street and Number of Europe Baltimore, Mary Land 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 11/7/09 Lansdowne, Maryland 1 □ **X**urial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facili}Chatman-Harris Funeral Home 5240 Reisterstown_{Rd} Baltimore,Md 21215 21. Signature Puneral Service Li P 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Due to (or as a cont equence of): Isalymic disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Ronal Falluro 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

2

Funeral

Director

show

28a-f

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Exeminer must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

The

Physician;

Hospital or Attending

Box 68760,

P.O.

Records.

Division of Vital

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Its Ma

Examine burial-transit and attending physician for use as the buria as signed by the a has page 2 certificate

director, After this

death. within 24 hours after death

To the Funeral Director:
completely filled in by the t

Physician/Medical þ Completed Be ျှ Certification:

Medical

State Registrar

25. Was case referred to medical examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

1 Yes 2 No 5 ☐ Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 HOther (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year)

Randallstown

nupleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DOYAV

and manner stated.

32. Registrar's Signature

31. Date filed (Month, Day, 09

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 12 per inf 8899 1-22-10 yr
Liate of Maryland / Becartment of Health and Mental Hygiene

Amend Item 26 per me, 8897, 11/09/09dhb

Certificate of Death

Reg. No. 2 1 1 9 For State Registrar Reg. No. 2 | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:20 AM Month October 31, Year 2009 John Donald Stees Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Min. 78 Aug 10 Year 1931 Marvland 213-30-5731 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 21 No Baltimore Sparks Glencoe 10e. Street and Number 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral United States 21152 1007 Upper Glencoe Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Bendix Field Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John G. Stees Althea Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Stees /Daughter 3509 Houcks Mill Rd. Monkton, MD 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov 02 cemetery, crematory or other place) 1 Burial 2 Fremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 21. Signature of Funeral Service Licensee M01442 22. Name and Address of Facility Cremation and Funeral Alternatives Þ 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final light.on Ph sician/ om disease or condition Medical resulting in death) Due to (or as a con equence of): **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury executed the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year been signed by the a should be detached it 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? reme frilere - Herrodia Lysis 1 Yes 2 No 3 Probably 4 Unknown Vertebral osteomyelite 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atole ST Disense Hes Hypertensin, A page 2 autopsy performed? Yes 2 After this certificate has strokes 1 Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{\text{Nursing Home}}\) 1 Residence 6 \(\text{X}\) Other (Specify) Hospice Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28d. Describe how injury occurred convitnessed third cover with board a "thoug" who the was in the Bath room 28b. Time of 28c. Injury at injury 1 🔲 Natural 5 Pending 1 ☐ Yes 2 No October7,2009 UNKNOW! 2 Accident Investigation after death Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Horru 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1007 Upper Glan Coe Ru Sy AVKS, MO 21152 determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Day, Year) un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. C. Ley GBM(1670) W. C. A. Chorles 31. Date filed (Month, Day, Year) 32: Registrar's Signature State 9 Registrar

Amend 29d per MD g897 11/9/09 TT State of Maryland / Department of Health and Mental Hygiene 2009 35884 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day MILDRED K. SHEFF OCTOBER 30 2009 12:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ATRIUM VILLAGE OWINGS MILLS BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 01/22/1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F 220-22-2891 96 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showning nijury or other traumatic event, the Mardical European Space. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕱 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 BALTIMORE SLADE AVENUE, APT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [Yes 2] No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify. WHITE 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN KATZ ANNA WEISBFRG ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD SHEFF/SON 5902 ROLAND AVENUE, BALTIMORE, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State **¼** Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW FRIENDSHIP 4 ☐ Donation 5 ☐ Other (Specify) 11/02/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Deho Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner equerior of). The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the I IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) detached the 9 🗌 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 K No certificate 2 🗆 No 1 □Yes 1 ☐ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSKIUC Hospital: 1∐Yes 2⊠No After this funeral dir ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 3 🗌 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, 10/30/09 30 Name and address of person who congleted squee of death out Not Bookinge, DO 31. Date filed (Month, Day, Year) State NOV 09 Registrar

DHMH 17 Rev 1/2001

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ı	Physici		1. Decedent's Name (First, Middle, Last Edith Edward	1 7%	MPSC	20		2. Date of Deat Month	Day Yes	3. Time of Death 12:58 PM
n'it	/Medic Examir		4a. Facility Name (If not institution, give		mpse		Location of Death		4c. County of D	eath
	Funeral		5. Social Security Number 6. Se		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign
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	Aaryland f show ad at	ö	10a. State 10b. County	0	Town or Lo	//				10d. Inside City Limits 1 Yes 2 □ No
	or 28a-	Director	10e. Street and Number	110	4/10/	10f. Zip Code		1	0g. Citizen of What	Country?
	fier death with the Marylar r Items 23a or 28a-f show ther roust be notified at	Funerail	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		merican Indian,
920	40 0	þ	1 ☐ Never Married 2 ☐ Married 3 ★Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Hican, etc.)	Specify:	hite, etc.
215-0036	in 72 hours "natural", butcal Exa	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	lurina most of work	ing	16b. Kind of Busine	ss/Industry
21	be filed within 72 ho ital Hyglene. id other than "natur event, Ir e Moulcal		Elementary/Secondary (0-12)	College (1-4or 5+)		Cook			Restaur	rant
Maryland	ould be fi I Mental H Narked ott Natic ever	To Be	17. Father's Name (First, Middle, Last) Herbert Will	burt Edh	lara.	5	18. Mother's Name	Ellen	Maiden Sumame)	nan
Mary	d 2 sh h and 7 Is m treum	•	19a. Informant's Name/Relationship (T)		19b. Mailin	0 111	and Number or Run	Route Number	City or Town, State	a, Zip Code) 24/11/2
ore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b. Pla	ace of Dispo	osition (Name of matory or other place			20c. Location - City	or Town, State
Baltimore	구두라는		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens	Centi	ral B	Aptist Chunc Name and Addres	h Cem 10- is of Facility 100	21-09 2 Marca	Body C	West VA
Ä	Dep. Impo		I look V. Do	w-	H	amlar - C	urtis Fun	eral Ho.	mc, Roanor	
	Pnysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate or condition.	ne cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est, •	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	D (or as a cons	ence f):	1 1	01	3	7	May
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):	OCIIVE	I UIMO	nary	/IS EASE	10 years
,	cate be executed physician and the burial-transit	Examine		c Due to (or as a conseque	ence of):					
8760	cate be executed physician and the burial-transit	dicai	· ·	1.						
Box 6	death certifii e attending p od for use as	an/Me	Zob. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of	
o.	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown		Other (specify)			Month	Day Year
Δ.	es De	by	Part II. Other significant conditions con Alzheimer's	- 1		nderlying cause give	en in Part I.			to the cause of death? Probably 4 Minknown
ecor	ne taw requir has been si ge 2 should	Completed						24a. Was ar		autopsy findings available to completion of cause of
of Vital Records,		е Соп	25. Was case referred to medical				OC Place of Death	perform	ned? death	es 2□ No
of Vi	dis ye	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)		ER/Outpatier		4 Nursing no	me 5 Reside	nce 6 Other (S	pecity) Home
ion	Attending F r death. ctor: After by the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at :? ∕es 2 □ No	28d. Describe ho	w injury occurred	
Division	ol or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
-	tospite 4 hours Funerel ely fille	edical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examination	vledge, deatl	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the ca	use(s) and manner ate and place, and c	as stated. lue to the cause(s)
)	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License			9d. Date signed (Mo	onth, Day, Year)
			30 Name and address of parron who as	Maule of death (from	le C	Print)	R08663-	,	10/26/0	9
_			30. Name and address of person who co	All CRNP	325	o Starting	g Cate a	- Woolh	ine Md	21797
	Sta Registr		31. Date filed (Month, Day, Year)	3 Registrar's Signat	To So	" معب				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 age of Meryland, Perostynant of Health and Mental Hygiene 2009 For State Registrar 35886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Pone Wilson 3:42 PM M October 20, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. unk 50 Director July 10, 1959 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at MD Director Montgomerv 1 ☐ Yes 2√ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 3227 Bel Pre Road 20906 Funeral USA 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2X No ≥ Specify. Specify: black 3 Widowed 4 Divorced natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4or 5+) 7 is marked other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 1 and 2 should be Health and Mental ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 If item 27 or other t Montgomery General Hospital 18101 Prince Phillip Drive Olney, MD 20832 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If itel
any Injury or ott Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation _3 Removal from State 4□Donation 5XOther(Specify) in state Signature Funeral Social Sicensee Ronald S. Wade, 22. Name and Address of Facility Mirector State Anatomy Board 655 W. Baltimore Street 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or c dition resulting in de 1h) Physician MULTILOBAR PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ENDOCARDITIS burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SEPTIC SHOCK 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Autonomy within 24 hours after death.

To the Funeral Director; Af 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifie (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

D59418

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32. Registrar's Signature

OLUYEMISI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADEWUNMI

31. Date filed (Month, Day, Year)

NOV 0 6 2009

OCTOBER 22,2009

			_ FOI	partment of Health and Mental Hygiene
			Registrar	ertificate of Death Reg. No. 2009 35887
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
3	Examin	er	Good Samaritan Hospital	Baltimore
70	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		220-18-6764 1□M ¾F 83 Yrs	Months Days Hours Min. (Month, Day, Year) Country) Nov. 5, 1925 MD
	p ,		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or	Location 10d. Inside City Limits
	laryla shor	ŏ	MD Baltimo	
	the N 28a-1 Potifie	rect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	3a or		5632 Anthony Avenue	21206 USA
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene matural", or items 23a or 28a-f show orth, the Modeal Evaminer must be notified at	Funeral Director		B. Was Decedent of Hispanic Origin? (Specify Yes or No-
ဖွ	after or ite mine		1 □ Never Married 2 □ Married	
003	ural",	Completed by	3 Widowed 4 ☐ Divorced Year or Dates:	- Diack
5	"natu	lete	15. Decedent's Education 16a. De (Specify only highest grade completed)	zedent's Usual Occupation 16b. Kind of Business/Industry ve kind of work done during most of working . DO NOT use retired)
12	withir lene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+)	
0	filed I Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
an	Aental Aental rked c tic ev	To B	Percy Parham	Adell F. Williams
Maryland 21215-0036	2 shot and N is ma rauma			illing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and and and and and and and and and and		Inita Williamson 563	2 Anthony Ave. Baltimore, MD 21206
Ore	Pages 1 nent of H int: If ite iry or otl		REBURIAL 2 LI Cremation 3 Li Removat from State 1	position (Name of Date 20c. Location - City or Town, State ematory or other place)
altimore,	t. Par rtmen rtant:		4 □ Donation 5 □ Other (Specify) □ Trinit	Cemetery 11/4/09 Dundalk,MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Moderal Evaminer must be notified at once.		21. Signature of Funer Servic Scensee	22. Name and Address of Facility Wesley Chavis, Jr. FH 2007 Eastern Ave. Baltimore, MD 21231
		\dashv	23a. Part1. Enter the disease of complications that cause the death. Do not shock, or heart failure state only one cause on each line.	
	Physician		Immediate Cause (Final	Olisot and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	spective fulmerery three years
	Examiner		b.	
	₽ #	ner	Sequentially list conditions, if any, leading to him-eular cause. Enter Underlying Cause (Disease or injury that initiated events	
36	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	
8760,	icate be executed physician and the burial-transit		Due to (or as a consequence of):	
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9 x c	w requires that the death certifice been signed by the attending is should be detached for use as	Physician/Me	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
P.O. Box	death e atte d for u	icia	in the past 12 menths?	B ☐ Ectopic pregnancy Month Day Year ☐ Other (specify)
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ord	equir	ted	145 plr flusion	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ec	faw r nas be	Completed	Scolissis	24a. Was an autopsy findings available prior to completion of cause of
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<u> </u>	sician certifi ector	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)
of	ling Phys n. After this funeral dii	<u>ا</u>	1 Yes 2 No	4 Nuising Home 5 Residence 6 Other (Specify)
Division of Vital Records,	nding th. Afte fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injur 2 ☐ Accident investigation	/ Work? M 1 □ Yes 2 □ No
<u>Visi</u>	Atter	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office 28f. Location (Street and Number or Rural Route Number,
ā	salor s afte al Dir	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours attendenth. To the Funeral Director: After this certificate has been signed by the attending from the Funeral Director. After this completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Examiner: On the basis of examination and/o	hath occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the h	Medical	one) and manner stated.	20e Lingues number 20el Date signed (Month Day, Year)
	2	<	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			20 Notice and address of power in a solidated and districts (the solidated and solidat	9 103 1 7 CCTOIUN 3 0 , 800 1
	2		30. Name and address of person who completed cause of death (Item 23a) (Tyr	e. Prints L. Pavar Boulevard Fre Hinase, Mary buch
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, and fund
	Registr	ar	MOV 0 9 2009 But A. Son	plant in the second of the sec

State of Maryland / Department of Health and Mental Hygiene 35888 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Francine A. Williams 7:23 PM 2009 Novembr /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Agnes Bultmore Minlthiure 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ XF 219-80-9674 Director 8/7/60 MD Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location Baltimore 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it without Evanture rough be notified at 10d. Inside City Limits MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, It is in 150 for item 188 ben 3535 Cedar Rd - Unit A 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian African 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No à SpecifAmerican 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Sales Clerk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sales Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Williams Mary E. Craiq 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3535 Cedar Rd-Unit A, Balt., MD 21228 Andre' Beatty/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/11/09 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature Finer | Service Licer ee Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chebral 15ch emil UNKNOWN resulting in death) /Medical Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerchin Examiner Due to for as a consequence of physician and the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as th IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate | 25. Was case referred to medical examiner?
1 7 Yes 2 3 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elci 900 Cuton Avenue Maltunore 31. Date filed (Month, Day, Year) 32. Registrar's Signature 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death

for State Registrar

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.

Phy /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar		,	Certi	ficate of l	Death	R	eg. No.2	009	35889
Physici	ian	1 Decedent's Name (First, Midd	ARMENTO	-600	- GARCIA 2. Date of Month					Year (Sq	3. Time of Death
/Medi	cal	FATRICIA 4a. Facility Name (If not institution		- GAR		h City Town or	Location of Death	70	10.00	unty of Death	1847 M
Examir	ner	Mandrin Chesape		House	7	Harwo				nne Aru	ındə1
uneral	Г	5. Social Security Number	6. Sex 7. Age	(In yrs. last bir		If Under 1 Year Months Days		8. Date of Birth			lace (State or Foreign
irector		220-63-2386	1□ M 2 F 47	<u>-</u>	Yrs.	violitis Days	Tiodia Willi	(Month, Day, 11/15/	1961	Mexi	
Mo #		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town	n or Locat	tion				10	Od. Inside City Limits
a-f sh	tor	Maryland Prince	e George's	Lan	ham						1 □Yes 2 □ No
or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Coun	try?
s 23a	ral	5632 Whitfiel	ld Chapel Rd.,			20706			Mex	ico	
item	Funeral	11. Marital Status 1. □ Never Married 2 Mar	12. Was Decedent Ev Armed Forces? rried 1 ☐ Yes 2 ☑ No	ver in U.S.	13. Was	s Decedent of H es, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e	
al", or	δ	3 ☐ Widowed 4 ☐ Divorced	I If Yes Give	•	1 🗓	Yes 2□No	Specify: Mex	ican	Spe	ec <i>ify:</i> Wh	nite
natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a.	(Give kin	it's Usual Occupa ad of work done of	durina most of worki	ng I	16b. Kind o	of Business/Ind	lustry
than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)			NOT use retired emaker	()		и	ome	
other ent, I	Be	17. Father's Name (First, Middle,	, Last)		HOINE	- IIIakei	18. Mother's Name	(First, Middle, N			
arked atic ev	To B	Alberto	Armenta				Guad	lalupe Oa	sorni	0	
is me	ľ	19a. Informant's Name/Relations			_		and Number or Rura				•
em 27 ther t		Norberto Garcia	a/ Husband				d Chapel			am, MD on - City or Tox	
it: If it		1 Burial 2 Cremation 4 Donation 5 Other (S		(on (Name of ory or other place	i			,	
Important: If it ment is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the notified at once.		21. Signature of Funeral Service	1	такеш		Cemetery lame and Addres	i 10/2	3/09 rge P	<u>Davi</u> Kalas	dsonvil Funera	. <u>Le, MD</u>
8 8 3		- Mount Ven					mons Isla				
			r complications that caused the tonly one cause on each line	he death. Do r	not enter t	the mode of dyin	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
sician edical		Immediate Cause (Final disease or condition resulting in death)	_a			WID	ELY 1	METAS	TATIC	-	Yeur
miner			Due to (or as a	consequence o	of);						
.±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5. Suc to (or as a	nonsequenne d	oty						
and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to les es e		-6\-						
sician											
ig phy: as the	Medical		d								
tendin r use	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2	pregnancy	3∏F(ctopic pregnancy	,		23d.	Date of delive	•
the at hed fo	Physician	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown			5 Other (specify)			Month Day Year		
ed by detac		Part II. Other significant conditi	ons contributing to death but	not resulting in	the unde	rlying cause give	en in Part I.	23e. Did tob	acco use o	contribute to the	e cause of death?
an sign	ed by							1 □ Ye	s 21 N	o 3 Proba	ably 4 🗆 Unknown
as bee	Completed							24a. Was ar			osy findings available
page	Com							autops; perform 1 □ Yes 2	ned?	death?	npletion of cause of 2 □ No
certific ector,	Be	25. Was case referred to medica examiner?	Hospital:			Oth	26. Place of Death	(Check only one	9)	N A	MORIN
er this eral dii	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient		tpatient :	3 ☐ DOA Othe	4 LI Nursing Hor	ne 5 Reside		Other (Specify	Hospite
r: Afte	atior	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	ng (Month, Day, 1	<i>Year)</i> Ir	njury	Work	? Yes 2□No	204. 20001120 110	, ,	001100	HUUSE
irecto	Certification: T	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		/ - At home, far (Specify)	rm, street,	factory, office	2	28f. Location (Str City or Town	reet and Nu . State)	ımber or Rural	Route Number,
aral Di		00-0-0	Įų.								
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best of Examiner: On the basis of e and manner state	xamination an	e, death od d/or invest	ccurred at the tim tigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	ause(s) and ate and pla	d manner as st ce, and due to	ated. the cause(s)
To the	Me	29b. Signature and title of certifie	A	Λ		29c. License	number	29	od. Date sig	gned (Month, E	Day, Year)
		Mich	aly ols	ntu.	m	1	214:	38 1	de	sper :	21,2009
(.)		30. Name and address of person	who completed cause of dea	th (Item 23a) (Type, Prin	Detra	ISE HIGH	WAL A	NNA	900 W	101/101
Sta	te	31. Date filed (Month, Day, Year)	A A A A A A	s Signature			ast Irida	١١٩٤١		Jeij 1.	17 51 70 /
Registra		OCT 2:	2 2009 Jenen	N B.	Soci	Med					

Registrar

			1 _ State	partment of Health and Mental Hy e <i>rtificate of Death</i>	
			Decedent's Name (First, Middle, Last)	2. Date of De Month	0.7.11.00.1.20.11.1
	Physici /Medio		James W. Antrim	October	c 21 2009 9:25 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1921 Marconi Circle	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1		rth 9. Birthplace (State or Foreign Country) 11, 1921 Nebraska
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
	ne Maryk 8a-f sho otified at	Director	Maryland Anne Arundel	Annapolis	1 □Yes 2X No
	th with the 23a or 2 ust be no		10e. Street and Number 1921 Marconi Circle	10f. Zip Code 21401	10g. Citizen of What Country? U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is fixed by Fyminer must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW II	8. Was Decedent of Hispanic Origin? (Specify Yes or North If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ★ 40 Specify:	14. Race - American Indian, Black, White, etc. Specify: White
5-0	"natul	letec	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	d withir giene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Cashier	Coca Cola
and	ild be filed fental Hyg ked othe lic event,	To Be C	17. Father's Name (First, Middle, Last) Wallace Ellwood Antrim	18. Mother's Name (First, Middle Marguerite Gert	
Baltimore, Maryland 21215-0036	and 2 shou saith and M 127 is mai er traumai	-		iling Address <i>(Street and Number or Rural Route Numb</i> 4 Whitehall Road Annapol	ner, City or Town, State, Zip Code) is, Maryland 21409
more	Pages 1 and the substitution of the substituti		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	position (Name of Date ematory or other place) ore Crematory 10/22/2009	20c. Location - City or Town, State Baltimore, Maryland
Balti	permit. Departn importa any inju			22. Name and Address of Facility $$ John $$ M. $$ T $$ 47 Duke of Gloucester St. $$	_
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		Interval Between
	Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	rdiac Arrhythmia	
		ner	Squandially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	tery Disease	
	executed n and al-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C		
68760,	ificate be executed physician and is the burial-transit	edical	d		
O. Box (The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		B □ Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
ds, P.	uires that signed b d be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
ecor	e law require has been si le 2 should b	Completed	Aprial Fibrillation	24a. Was	psy prior to completion of cause of
tal H	siclan: The certificate h		25. Was case referred to medical	perfo 1 □ Yes 26. Place of Death (Check only	ormed? death? 2 No 1 Yes 2 No
<u></u>	nysicle nis cer direct	ro Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	
Division of Vital Records,	Attending Physiclan: If death. ector: After this certification by the funeral director.	ation:	27. Manner of Death 1		how injury occurred
Divis	al or Atte s after de il Directo ed in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear one) 1 Medical Examiner: On the basis of examination and/or and manner stated.		
	To th Vithii Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type		10/21/2009
()	At D		SALVATORE S. LAURIA MD 31. Date filed (Month, Day, Year) 32. Reflistrar's Signature	128 Lubrano Drive #300	Annapolis, MD 21401
	Sta Registr		31. Date filed (Month, Day, Year) OCT 22 2009 32. Registrar's Signature	parke	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per phys. C897 11/9/09 dk

State of Maryland Department of Health and Mental Hygiene 2009 35891 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 21, . 2009 **Physician Brown** Teresa Mary 1725 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner WMHS--Memorial Campus Cumberland Allegany 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ ₹ Months Days Hours Min. 219-54-1647 ΜD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at MD Allegany Cumberland Director 1 □¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 414 Race Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **X**o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □**X**o If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) **Dietary Department** s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis E. Rummer Teresa A. (Counihan) Rummer P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Brown husband 414 Race Street Cumberland MD 21502 permit. Pages I an Department of Healt Important: If Item 27 any injury or other tragnes. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2009 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Fune I Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTRA CEREBRAL PLEED HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans SERSIS Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 ☐ Other (specify) hed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by sign be cate has been si 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 To the I 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) ANIKOMMU M.D 23 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 DX

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

CUMBERZLAND, MP

SANIKOMMU, M.D. 900 SETON DR

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2009 35892 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 22, 2009 **Physician** 4:25 Рм Rita Dolores Brinley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 02/22/1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 KF New York 75 Director 060-28-0129 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show t√∑Yes 2 ☐ No Director Bethesda MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 20817 United States Funeral 6306 West Halbert Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 13-200.00. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2X Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Lawyers Firm Manager of Legal Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Brogna Michael Silvestri ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6306 West Halbert Road Bethesda, MD 20817 Ronald Kent Brinley / Spouse 20c. Location - City or Town, State 20a. Method of Disposition Plece of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/2009 Germantown, MD All Souls Cemetery 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Lie 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Breast Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed hin 24 hours after death. Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed' certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending investigation within 24 hours after vector. At to the Funeral Director. Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rehou 163748 October 23, 2009 · Koud 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyn Kouatchou MD 6001 Muncaster Mill Road Rockville, MD 30855 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

UCT 27 2009

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 40 PM **Physician** BERG KOSE 10 00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KOCKVILLE MONTGOMERY 10 HOME CKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 578 14 9508 96 Washington, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Olney Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4029 Evangeline Terrace 20832 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐ Yes 2. If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Babinski Maru Schneidstein ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 so cartment of Health an cortant: If Item 27 Is re injury or other traus Marian Apple - Daughter 4029 Evangeline Terrace, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Gardens
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 10/27/2009 Falls Church, VA 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Fu eral S vice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M0070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer ears disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1□ Yes 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ∰lo 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Year) 2 Accident

ending physician and use as the burial-transi Box 68760. pe atten for u signed by the a d be detached for P.O. I Division or Vital Records, page 2 funeral After spital or Attendii nours after death. neral Director; A

72 hours after

d 2 should be filed with and Mental Hygier 7 Is marked other th

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Shanna

6 ☐ Could not be determined

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

DO\$61382

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 26 09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

303 Adclare Road, Rockville, Maryland Mittal. M.D., Shama R. 31. Date filed (Month, Day, Year)

State Registrar

Medical

27 2009

To the Hospital within 24 hours a To the Funeral C Hospital

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Randall Allen Brooks Oct. 23 2009 2:07 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. 217-62-6524 57 Director July 20, 1952 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It whedical Examiner must be neethed. 10d. Inside City Limits Directo 1 Yes 2X No Delaware New Castle Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Mt. Pleasant Trailer Ct. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Millard A. Brooks ၉ Jessie Blackburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie B. Hackbarth/Mother 38 Mt. Pleasant Trailer Ct., Middletown, DE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10-27-2009 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Baptist Cemetery Rising Sun, Maryland 21. Signature of Funeral Service Lensee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 . Pp. 11. Enter the clease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or hear, filter. List only one class on each line. Approximate Interval Between Onset and Death Immediate Caus Final disease or con July n resulting in de fin) **Physician** SWERE COACHULOPATHY WITH END STAGE LIVER DISENSE /Medical Due to (or as a consequence of): Examiner MULTISYSTEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ALCOHOL ABUSE sician and burial-tran Due to (or as a consequence of) 68760 attending physician Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performe 1 □ Yes 2 1 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOD109118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIVA PUTHAWALA MD 20 KHALLD BELAIR MD 21014 1002 ATLOODD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2009 Registrar

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			State of Maryland / Department of Health and Certificate of Death	d Mental Hyg	iene _{eg. N} 2009	35895	
		E	Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death	
	Physici /Medi		Braxton Bragg Baker	October	22 2009		
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of De	ath	
7			Charlotte Hall Veterans' Home Charlotte Hal 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H		St. Mary		
п	Funeral Director		420-52-5435 1 A 2 F 85 Yrs. Months Days Hours M	in (Month, Day	Year) 1923 A1	irthplace (State or Foreign Country) abama	
	pu ,		Usual Residence of Decedent	pcc. 1,	1525 ////		
	ith the Maryland or 28a-f show ce notified at	'n	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 📉 No	
	28a-f	Directo	Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code	11	0g. Citizen of What C	<u> </u>	
	ath with s 23a or	Ö	2654 Sun Valley Drive 20603	'	USA	outiny:	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - An		
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinat must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No □ □ 1 □ Yes 2 □ No Specify:	erio Rican, etc.)	Black, Wh		
Maryland 21215-0036	"natural", or items	ed b	3√ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	White	
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212	d with glene er tha	No.	Selementary/Secondary (0-12) College (1-4or 5+) 9th. Air Craft Mechanic	l	J.S. Navy		
pu	1 and 2 should be filed within 72 hour Health and Mental Hyglene. em 27 is marked other than "natural ther traumatic event, the Medical E.	To Be (17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle, M	faiden Surname)		
yla				Roberson			
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or				
<u>ē</u>	f Heal tem 2		Mary Cusick/ Niece 1753 Red Oak Lane. Wa 20a. Method of Disposition 1753 Red Oak Lane. Wa 20b. Place of Disposition (Name of cemetery, crematory or other place)		cyland, 20 20c. Location - City o		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Once.		TW Burlar 2 Cremation 3 Chemoval noni State	. 27, 2009	Revantou	m MD	
alti	permit. Departm Importa any inju once.		04.01 1 45 10 1 11 5 4 4	untt Funer		ווין ויוט.	
<u> </u>	8 9 7 2 8		12, Walf MO11903035 Old Washingto	n Rd. Wald	dorf. MD.	20601	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory arre	est,	Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition resulting in death)			Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):				
		Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)				
			cause. Enter Underlying Cause (Disease or injury that initiated events c. <u>Peripheral Arkerial Disease</u>				
That illitated events resulting in death) Last resulting in death) Last Due to (or as a consequence of):							
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Вох 6	certifi nding use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Data of d	olivom.	
Ã.	death	Physician/M	was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of delivery Month Day Year	
P.0	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 Hours after death. Within 24 Hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hys	9 ☐ Unknown				
S,		βy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?		
ord		ted	Caroted Artery Disease	_ 1 □ Ye	s 21⊈146 3∏ F	Probably 4 Unknown	
of Vital Records,	elaw hasb ie2sh	Completed		24a. Was ar autopsy	y prior to	utopsy findings available completion of cause of	
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Ξ	rsicla s certi lirecto	o Be	examiner?	eath (Check only one			
οί	ending Phy eath. or: After this he funeral d	Ë.	27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Reside		ecify)	
Division		Certification: To	2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No				
ξ	or Att	ıţįį	3 ☐ Suicide 4 ☐ Homicide 1 ☐ Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town,	reet and Number or F , State)	Rural Route Number,	
Ω	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla				
	e Hos 24 hc Fun e Fun	Medical	(Check only one) Check only one Check one Check only one Check one Check one Check one Check	ace, and due to the ca ccurred at the time, da	ause(s) and manner a ate and place, and du	e to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)	
			mo D67814		10/22/09		
(Duci		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
4	13918		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCISCA BRUNEY, MD 29449 CHARLOTT HALL RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 11. 26 2009	CHARLOT	TE HAU M	D 20622	
	Sta Registra	ate trar	ACT 2 6 2009 Duna B. Jack				
			3161 60 2003 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 15 Wanda Marie Kennedy Bouknight 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6 evers cheverly Prince Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Year) 1□M 2**ॉ**F Months Days Hours Min 51 577-78-3064 12-23-1957 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Twes 2 □ No Washington, D.C. D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1249 Mount Olivet Rd N.E. #3 20002 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. Specify: Black 3 ☐ Widowed 4 ★ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Group Leader 12th 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Wandy C. Kennedy Elaine Marie Yate Kennedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nikita R. Bouknight - Daught. 1249 Mount Olivet Rd N.E. #3 Washington, D.C 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Memorial 10-27-09 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2019 MLK D.L. McLaughlin Funeral 21. Signature of Funeral Service License 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscleratic Hypertensive Heart Dise disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DUAS et es 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an

Physician /Medical Examiner

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ite Fedical Evaniter must be a cultical at

72 hours after death with

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Pages 1

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

other t

Baltimore, Maryland 21215-0036

/Medical

burial-trar

Examir Physician/Medical ð

attending physician for use as the burial the signed by t page 2 should peen has Hospital or Attending Physician; The certificate this After death. i Director: n 24 hours after de le Funeral Directo bletely filled in by th

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed Be Certification: To

Medica

completely within 2 To the I

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No

J. Was case lelel	red to medicar	26. Place of Death (Check only one)					
examiner? 1⊿ Yes 2□	No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient	3 🗆 [OOA Other: 4 Nursing H	lome 5 Residence 6 Other (Specify)	
7. Manner of Deat 1 ☑ Natural 2 ☑ Accident	5 ☐ Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	t, facto	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Qa Certifier	1 Certifying Ph	welcian. To the best of my kny	wledge death	COULTE	d at the time, date and place	and due to the cause(s) and manner as stated	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

one)	and manner stated.
29b. Signature and title of certifier	
Her mole	ANO DO

29d. Date signed (Month, Day, Year)

20

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

State Registrar

Medical

29a. Certifier

29b. Signature

(Check only

and title of certif

BAHRAM PISHDAD, MD 1328 SOUTHERN AVE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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within 24

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

51520

SE WASHINGTON, DC 20032

29d. Date signed (Month, Day, Year)

10.21.2009

			for State Registrar	Otate of Mic	Ce	rtificate of			Reg. No.		
	Physici		1. Decedent's Name (First, Middle, Las Anne Je	essica	Cohen			2. Date of Dea Month	Day 2009	Year	3. Time of Death 11:40a
	/Medic Examin		4a. Facility Name (If not institution, give				or Location of Death	000,2	4c. County		111.404
		-	2115 Hanover S	Street		Silve	r Sprinc	1	Mont	.aom	erv
	Funeral Director		197-44-3797	ex 7.Age	6 (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 3 / 214, / 1	952	9. Birth Call	ery place (State or Foreig Itornia
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation				1.	10d. Inside City Limits
	f sho	ō	MD Montgon	nery		Spring					1 ∐Yes 27 No
	with the Na or 28a-	I Director	10e. Street and Number 2115 Hanover S	Street		10f. Zip Code 2091	0		10g. Citizen of V	What Cou	ntry?
30	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Madical Everiffuer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 November 1 Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 XNo	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	e - Ameri ck, White,	
2-00-c	atural	ted I	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of B	usiness/In	dustry
	thin 72 ie. an "ne	Completed	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of work d)				
7	filed within Hygiene. other than "	Con		4	Pho	tograph			Federa		ov't
alla		Be	17. Father's Name (First, Middle, Last) Alvin Cohen				18. Mother's Name		Maiden Surnan	ne)	
Z		ပ					Lois L				
20	s 1 and 2 should of Health and Me item 27 is marke other traumatic		19a. Informant's Name/Relationship (Richard Michae	^{Type. Print)} husb :1 Gallow			and Number or Run				o <i>Code)</i> • Md • 2091 (
บ์	1 and Health lem 27 other ti		20a. Method of Disposition		20b. Place of Dispo cemetery, crei			Date Date	20c. Location		
Dallillion	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)			matory or other place eake Cre		7/2009	Belt	svi	lle,Md.
	mit. F partm sortar Injur		21. Signatur V I neral Servi — c n				SRINALDI	FIINER			
	Physician		23a. Part 1. Enter the disease, or com shock, or heart allure. List only Immediate Cause (Final	one cause on each lir	the death. Do not en	241 Colu	umbia Bl	vd.Sil	ver Sp		Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	и.	atic brea	ast cand	cer			-	10mo.
	Examiner =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Prior	Stage II	breast	cancer				3yrs.
,00,00	rtificate be executed ng physician and as the burial-transit	al Examiner	Due to (or as a consequence of):								
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O. DOX	eath ce attendi for use	Physician/M									ery Day Year
ŗ.	that the post of t		Part II. Other significant conditions c	ontributing to death bu	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use con	ribute to t	he cause of death?
colus,	quires in sign	d by						1 □ Y	es 2ሺ No	3□ Pro	bably 4 ☐ Unknow
משבר	ding Physician: The law requires that the d. h. After this certificate has been signed by the funeral director, page 2 should be detached	Completed						24a. Was a autop perfor 1 □Yes	sy med?	prior to co de <u>a</u> th?	opsy findings available ompletion of cause of
2	slan: ertifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deat				22,10
>	hysic his or	2	1 ☐ Yes 2 🙀 No		nt 2 ☐ ER/Outpatie		4 🗆 Nursing no	me 5 🛛 Resid	lence 6 □Ott	er (Speci	fy)
	ending P sath. or: After t the funera		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ry , Year) 28b. Time o Injury	Wor	ry at k?]Yes 2 □ No	28d. Describe h	ow injury occur	red	
2	ital or Attendurs after death ral Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, str :. (Specify)	eet, factory, office		28f. Location (S City or Tow		er or Rur	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 ☐ Medical Exan		of my knowledge, deat examination and/or in ted.	vestigation, in my	opinion, death occur	red at the time,	date and place,	and due t	o the cause(s)
)	O Verify To O	2	29b. Signature and title of certifier	Budu	1 M	D 29c. Licens	7236		oct. 2		
			30. Name and address of person who carolyn Hendr				ledge D	r_#506	Retho	e d a	Md 20217

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month; Day, Year) ----

OCT 27 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death COMER, SR. **Physician** 06 30 M 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, May 22, 6. Sex **Funeral** Months Days Hours Min Year) 1 ☑ M 2 ☐ F 579-48-5720 75 Virginia Director 1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, it is Marical Entrine to The Angles Once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 ŪNo Maryland | Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1509 Patuxent Manor Rd. 21035 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KYes 2 □ No If Yes, Give Year or Dates: 1951-59 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) D.C. Metropolitan Elementary/Secondary (0-12) College (1-4or 5+) Transit Authority 11th Bus & Metro Train Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ted Comer Myrtle Merica မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burnell Comer/ Wife 1509 Patuxent Manor Rd., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 10/21/09 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sabrige Cicenspe 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edg
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** asperation disease or condition resulting in death) /Medical Due to (or as a correquence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence on) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1☐Yes 2月No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? HUUSE Natural 2 Accident 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

MICHAER

32. Registrar's Signature Dark

Registrar

D21438

29d. Date signed (Month, Day, Year)

DEFENSE HIGHWAY ANNAPOUTMOLISM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician G. Cunningham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Heartland of Hyattsville Nursing Home Hyattsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 18, 1938 | South | Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-50-7162 71 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ural", or items 23a or 28a-f show I Examiner must be notified at MXYes 2 □ No Directo Maryland | Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6500 Riggs Road 20783 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**K N**O Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 'natural" Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12 years Government Procurement Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ental permit. Pages 1 and 2 should be Department of Health and lental Important: If item 27 is marked of any Injury or other traumatic ew is marked Lovie Cunningham, Sr. Mary Green ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Reid - Sister 428 Short Hills Dr. Charlotte, NC 28217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park Oct. 23, 2009 4 □ Donation 5 □ Other (Specify) Landover, MD of the eral Sarvice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardio respirator **Physician** ↑ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Be Completed KOS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate I nyumonia 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 2 ☐ ER/Outpatient this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After : Hospital or Attending 5 ☐ Pending investigation 2 □ No 1 Yes 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47867 Name and address of person who completed cause of death (Item 23a) (Type, Print) #216. ROCKVILL, MD ZOSSZ 701 Randolph Rd State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 35901 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Belinda Chambers 13:00 P ^M 9, October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Months Days Hours Min. 1 M 2 XF 579-72-8187 54 1955 | Washington, DC 26, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia 1√2 Yes 2 □ No Washington 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? 966 Florida Avenue, NW 20001 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐Yes 21 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ejementary/Secondary (0-12) College (1-4or 5+) Cook Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Lee Chambers Ella Felder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keyana Green - Daughter 6515 Gateway Blvd District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Heritage Mem. Cemetery Oct. 30, 2009 Waldorf, MD 21. Sonature of Funcial Service Licensia 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performi 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of wath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed P.O. Box 68760 Records, The Vital Physician: of

sician and burial-trans attending physician for use as the buria signed by the a cate has been si page 2 should b director funeral Hospital or Attending death. 24 hours after deat Funeral Director: completely filled in by the

Funeral

Director

show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the faction Examiner and to notified at

Hygiene.

Maryland

Baltimore,

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hyglen. Important: If Item 27 is marked other tha any injury or other traumatic event, Ilm. Once.

Physician

/Medical

Examiner

Division

5 ☐ Pending investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one

29c. License number

30. Name and addre. s of person who completed cause of death (Item 23a) (Type, Print)

me 31. Date filed (Month, Day, 32. Registrar's Signature Year) OCT 27

State Registrar

Medical

29b. Signature and lite of certifier

the

2

State of Maryland / Department of Health and Mental Hygiene 35902 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 P^{M} Cathy Cetinyan November 2330 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurelwood Care Center Elkton Cecil If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Days Months 1 □ M 2 🗓 F NOV 13, 1958 **Director** 221-46-9509 50 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the fredical Examinating be notified at 1 ☐ Yes 2 X No Director Maryland Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 62 Walnut Grove Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 👿 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify: White ğ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
T is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Automobile Automobile Sales Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward C. Merward Marie Dill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any Injury or other trau Christopher Bolinger/Son 256 Johnstown Road, Elkton, MD 20b. Place of Disposition (Name of cemeters crematory or other place).
International Institute for the Advancement of Medicine 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessup, PA 21. Signature of Funeral Service Licensee Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, iratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) dychores /Medical Due to (or as a consequence of): Examiner Eaguer Hally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed Exami to (or as a consequence of) attending physician a for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) signed by the a I be detached f P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð cate has been si page 2 should t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1∐ Yes 2∭XNo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou **To the Fune** completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Muhammed Nian CI-0005013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammed A. Niaz, M.D., 107 Bridge Street, Elkton, MD 32. Regi trar's Signature 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar 1. Decedent's Name (First, Middle,	tem 23a per	dr.,g8	97',1'1'/09 Certifica	of D	eath	2. Date of Dea		2009	359	303
	Physici		1. Decedent's Name (First, Wildale,	Agnes Lucil	1a Cur	r 17			Month October	Day	2009	3. Time of 1632	P ^M
	/Medic Examin		4a. Facility Name (If not institution,		Te Cui		Town, or L	ocation of Death			ounty of Death	1032	P
m. o.k)		Union Hospital	,			kton				Cecil		
	Funeral Director		5. Social Security Number 218-26-9803	. Sex 1 □ M 2 X F 85	(In yrs. last bir		r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 6	h y, <i>Year</i>)	9. Birthp Cour	olace (State o ntry) ginia	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town	n or Location						0d. Inside Cit	tv Limits
	the Maryland 28a-f show	힏			•							1 🗆 Yes	
	r 28a	Director	Maryland Ceci 10e. Street and Number	<u>L</u>	E1kt	10f. Zi	Code			10g. Citize	n of What Cour	itry?	
	death with the Maryland	a D	605 Blue Ball R	oad		2	1921			Ur	nited St	tates	
7, // 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the "Fe filed Extention once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? d 1 □Yes 2 ▼ No If Yes, Give Year or Dates:	er in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Americ Black, White, or Decify: Whi	etc.	
5-0	72 hc	etec	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usu	al Occupat	ion ring most of work	dina (16b. Kind	of Business/Inc	dustry	
121	vithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				ring most of work	9		1.1.0		
d 2	filed within Hygiene. rther than "		12 17. Father's Name (First, Middle, La	net)		Nursing		stant 8. Mother's Nam	e (First Middle		ealth Ca	are	
an	d be i ental ked o c eve	o Be	Franklin Huffma					Mahalia			arriamo)		
ary l	should and Men s marke umatic	은	19a. Informant's Name/Relationship		19b	. Mailing Address		-			Town, State, Zip	Code)	
$3a_{\gamma}$	and 2: ealth a n 27 is ier trai		Jerry Church/So	n		.0. Box						ŕ	
$23a,b,\rho$ Baltimore, Maryland	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State	20b. Place of cemeter	f Disposition (Natry, crematory or c	ne of ther place)	Octol	ber 29,		ation - City or To		
alti.	mit. F sartm oortar 'Injur		21. Signature of Funeral Service Li		Metho	dist Cen	etery nd Address	of Facility		Che	erry Hil	II, MD	
m	Depar Depar Impor any ir	0 1	Shuit of	1. Cuma)	Hicks	Home	of Facility for Fund kton St	erals, P	kton	MD 21	1921	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused th	e death. Do	not enter the mod	de of dying,	such as cardiac	or respiratory ar	rest,		Approximate Interval Bety) WOOD
	Physician	9. 9	Immediate Cause (Final disease or condition	12 0	(00 24	in (1)	nik					Onset and D	
	/Medical		resulting in death)	Due to (or as a c	-	of):	UCI		0.			- ///	HOVEL
	Examiner	_	Se wentially list conditions	b. Progre			culor	carcles	c tar	lune	-	24 60	2015
_	ted isit	nine	Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a c		,					c	evera1	WOOT
	rtificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary Due to (or as a c			se					CACLUI	year
68760,	e be e			d									
68	rtificat ng phy as the	Medical		0.					-	- 1			
		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 l 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (s _j				230	d. Date of delive Month	-	⁄ear
ت. ح.	res that signed b be deta		Part II. Other significant condition	s contributing to death but r	not resulting in	the underlying	ause given	in Part I.	23e. Did to	obacco use	contribute to the	ne cause of d	eath?
rds	quires an sig uld be	ed by	Acute re	ual fail	ure				1 □ Y	es 2	No 3□ Prob	oably 4 □ U	Jnknown
ဝ္တ	aw requir is been s 2 should	Completed							24a. Was a	an	24b. Were auto prior to co	psy findings a	available
Ä	The law cate has page 2 t	mo:	-		-				autop perfor 1 🗆 Yes	rmed? 2 ANo	prior to co death? 1 ∐Yes		ause of
İta	sician: The certificate l irector, page	Be C	25. Was case referred to medical examiner?				2	26. Place of Deat		_/	1 🗆 163	2 110	
<u></u>	hysic his ce Il dire	2	1 Yes 2 Alo			utpatient 3 D	Other:	4 Nursing Ho	ome 5 Resid	dence 6 [Other (Specif	<i>y</i>)	
<u>_</u>	ding Phys h. After this funeral dir	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	<i>(ear)</i> 28b. 1		8c. Injury a Work?		28d. Describe h	now injury o	occurred		
isio	Attendii death. ctor: A y the fu	icati	2 Accident Investiga 3 Suicide 6 Could no	bo		M		es 2 🗆 No	001				
	- E - C	Certification:	4 ☐ Homicide determin	28e. Place of Injury building, etc.	Specify)	rm, street, factor	, office		28f. Location (S City or Tow	street and I vn, State)	Number or Rura	J Route Numi	ber,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of recaminer: On the basis of earth manner states	x <i>a</i> mination an d.	id/or investigation	, in my opi	nion, death occu	red at the time,	date and p	lace, and due to	the cause(s)	
	To th Withir Comp	Me	29b. Signature and title of certifier	1		29	c. License r	number		29d. D <i>a</i> te :	signed (Month,	Day, Year)	
			· alfe as	in MI		Į.	1005	55/90		Octo	ber 25	200	9
	2		30. Name and address of person w	no completed cause of death	th (Item 23a)	(Type, Print)	06 B	ew Str	ect El	Efor	1413	2192	-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	arked	W						-
	Registra	ar	MUYUJZU	W CANDON	N. 17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Oct 23, V. Davis 2009 Ruth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Prince Georges Community Hospital Cheverly, Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 1 M 2 X F 6/21/1928 Bedford Cty, VA **Director** 577-44-1156 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Marical Examinar must be natified at **Clinton** Yes 2 No Maryland Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20735 8706 Shannan Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Black δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Ella Goode ၉ George North 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10035 Sunshine School Road, Woodford, VA 22580 John E. Davis, Jr. (Son) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Comfort Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/2/2009 Alexandria, VA 22POPEndPUNERATE II MOMES, P.A. 21. Signature of Euneral Service Licensee 5538 Marlboro Pike, Forestville, MD 20747 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner elun Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760,

ı	Due to (or as a consequence of
•	d
	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day Year

P

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4 ☐ Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ dnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an

25. Was case referred examiner? 1 ☐ Yes 2 ☑ N	
27. Manner of Death	
1—Natural	5 Pending investigation
2 ☐ Accident	investigati

IF FEMALE:

Completed by

Be

Medical Certification: To

23b. Was decedent pregnant

1 □Yes 2 ☑No 9 Unknown

in the past 12 months?

Inpatient 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day, Year) 28b. Time of 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐Yes 2 ☐No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performed 2. No

1 ☐ Yes

26. Place of Death (Check only one)

(Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00066940 29d. Date signed (Month, Day, Year)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thererly mp 20185

State Registrar

Division of Vital Records,

death. ours after death.

neral Director: A
filled in by the fu

To the Hospital or within 24 hours at To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35905 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ekubaselassie October 24, 2009 2:36 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9614 Washington Avenue Laurel Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 19, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) 1918 1**₹**] M 2□ F Days Hours Min. 218-57-3156 91 Eritrea Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Director 1 ☐Yes 2 X No Maryland Howard Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9614 Washington Avenue 20723 Eritrea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Police Officer Law Enforcement permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adal Ekubaselassie Gidey Mebrahtu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jirom Andit/Wife 9614 Washington Avenue, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct.Date 27 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ F 3 Removal from Gate of Heaven Cemetery 2009 Silver Spring, Maryland 21. Signature of Fineral Sea 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 io Livensee 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 5 yrs shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer Physician /Medical Due to (or as a consequence of): Examiner Bladder Cancer 1 yr. Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Kidney Failure 1 yr. resulting in death) Last Due to (or as a consequence of): Box 68760 Anemia 1 yr. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □ Yes 2 □ No this certificate 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2€XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 23, 2009 D0040804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kewal K. Sharma, MD 9801 Georgia Avenue, #342, Silver Spring, Md 20902 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2009

	1 - State Registrar 1. Decedent's Name (First, Middle	Loot		Cer	tificate of	Death	2. Date of Dea	Reg. No 20	09	359				
ian			ardt				Month Octobe	r 23, 2	0,63	3. Time o 5:25				
cal	4a. Facility Name (If not institution, Friends Nursin		·)			r Location of Death	L	4c. County	of Death					
Г			ge (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day July 7,	h	9. Birthpla	ice (State y) Maryl				
	Usual Residence of Decedent													
ō	10a. State 10b. County Maryland Mont	gomery	10c. City, To		y Spring				100	d. Inside C 1 □Yes				
Director	10e. Street and Number	gomery		Dana	10f. Zip Code			10g. Citizen of V	What Countr	y?				
	17330 Quaker	Lane			20860			U	SA					
by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' ed 1 Tyes 2 1 If Yes, Give Year or Dates:	? No	l II	Vas Decedent of H Yes, specify Cuba □Yes 2 🗷 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		e - America ck, White, etc /: Whit	C.				
ted	15. Decedent	s Education			ent's Usual Occup		ina I	16b. Kind of Bu						
Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	`life. E	OO NOT use retired	*	ang							
	8 17. Father's Name (First, Middle, L	.ast)		Н	omemaker	18. Mother's Nam	e (First, Middle.		n Home	9				
To Be	Frank Burdett	,					Belliso		•					
	19a. Informant's Name/Relationsh C. Diana Cerma		1			and Number or Ru ion Boule								
	20a. Method of Disposition 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ceme	etery, crem	sition (Name of eatory or other place eran Cem	ce) c	Date 2t. 27 2009	20c. Location -	•					
	21. Signature of Euneral Service L		un	Fr 50	Name and Addre ancis J. O Univer	ss of Facility Collins sity Blvd	Funeral	Home I	nc.					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final													
	Immediate Cause (Final disease or condition			ry Di	sease					Onset and LO ye				
	resulting in death)	Due to (or as	s a consequen	ce of):										
je.	Sequentially list conditions, if any, leading to immediate course Fract Underlying. Due to (or as a consequence of):													
Examiner	Cause (Disease or injury that initiated events c.													
	resulting in death) Last Due to (or as a consequence of):													
edica	d.													
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1													
	Part II. Other significant condition Diabetes Melli			g in the un	derlying cause giv	en in Part I.		obacco use contr es 2 No						
lete							24a. Was a		Were autops	sy findinas				
Completed by	25. Was case referred to medical					00 8' 17	1 □ Yes	med? c	prior to comp death?	pletion of o				
Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/	/Outpatien	t 3 □ DOA Oth	er: 4 X Nursing Ho		<i>ne)</i> lence 6 □Oth	er (Specify)	-				
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ation: To	3 ☐ Suicide 6 ☐ Could not determine	ot be ned 28e. Place of In building, e	jury - At home tc. <i>(Specify)</i>	, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	er or Rural i	Route Nur				
Certification: To		Physician: To the hest				me, date and place opinion, death occur								
edical Certification: To		xaminer: On the basis and manner s												
Medical Certification: To	(Check only 2 Medical E	xaminer: On the basis			29c. Licens			29d. Date signed						
	(Check only 2 Medical E	xaminer: On the basis and manner s	tated.		D18			Octobe						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 35907 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Margaret Granruth P MOct. 16 2009 5:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 11813 Grays Corner Road Berlin Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 M 2 F 96 Yrs. MD Director 214-01-3479 Oct. 1 1913 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho 1 □Yes 2 □ No Director MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 11813 Grays Corner 21811 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 🏖 ☐ No Specify: White þ 3 XWidowed 4 Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown John Holzheld 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau 11813 Grays Corner Rd. Berlin, MD 21811 Patricia Shifflet (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2009 | Hanover, MD Anatomy Gift Reg. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St.Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one can Immediate Cause (Final disease or condition resulting in death) Physician days /Medical Mue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burlan-transit completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Afris 1 🗆 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one Other: 4 \(\sum \) Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of o completed cause of death (Item 23a) (Type, Print) Ch ET AFTENDE 31. Date filed (Month, Day, Year) Pegistrar's Signature State **DCT** 2 6 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 35908 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Albert L. Giles, Jr. 12:45 /Medical 8. 2009 October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fox Chase Rehab. & Nursing Center Silver Spring Montgomery If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min 250-42-6135 79 Director Sept 16, 1930 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at Director 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 Edgewater Parkway 20903 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1√2 Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√2 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5+ College (1-4or 5+) Research Biologist Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Giles, Sr. Hattie Mack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Lillie Y. Giles - Wife 2012 Edgewater Parkway Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Wesley Mt. Zion Cemt. Oct. 24, 2009 Salter, SC 4 □ Donation 5 □ Other (Specify) 21. Signature of Furneyal Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. MM 4001 Benning Road, NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Gause (Final Physician Cardio pulmonary arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Nasal pharygeal cancer Sequentially list conditions Due to (or as a consequence of) cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Exami sician and burial-trans Pnemonia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Dementia IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Ye ar 4 ☐ Pregnant at time of death Month Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 □Yes 2√√No 1 ☐ Yes 2 ☐ No. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2🏝 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 🛍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067092 October 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove #208 Rockville, MD 20850 M.D.Weihan Wang, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** EPH ANIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Mandrin Anne Arundel Harwood 5. Social Security Number 224-11-4265 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 963 ^{untry)} Virginia 1 M 2 Z F 45 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Prince George's Lanham 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9005 Hilton Hill Terrace 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No þ Specify. 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, Ite Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Leroy Gant Edna Strothers မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Flores/Sister-in-Law 9005 Hilton Hill Terrace Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Valley Mem Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Annandale, VA 4 ☐ Donation 5 ☐ Other (Specify) 10/28/09 21. Signature of Fune | Service Licensee 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) METASTATI **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine This to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlal-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred House 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centifier 29c. License number

P

State Registrar OCT 2 7 2009

32. Registrar's Signature.

leted cause of death (Item 23a)

			1 - For State Registrar	State of Mar		artment of F rtificate of		лental Нуд я	giene Reg. No 2009	35910
	Dhysisi	22	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici: /Medic		Margaret D		ayre	Υ		Octobe	r 25, 200	8:30 p M
	Examin	ier	4a. Facility Name (If not institution, give	e street and number)			r Location of Death		4c. County of De	
p'	-		Holy Cross Hospital 5. Social Security Number 6. S	ex 7 Age /	'In yrs. last birthday)	Silver Sp:	5	8. Date of Birth	Montg	birthplace (State or Foreign
	Funeral Director			□ M 2 ☑ F	78 Yrs.	Months Days	Hours Min.	Feb. 3,	1931 Wa	Sountry) shington, DC
pua	X ::		Usual Residence of Decedent 10a, State 10b, County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
Maryla	f sho	tor		ntgomery	**	lver Spr	ing			1 □Yes 2 No
the	r 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
ath wit	23a c	ral	906 Snure Road			209	01		USA	
3-0030 72 hours after death with the Maryland	of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Evaminar must be notified at	by Funeral	11. Maritał Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 □Yes 2□ * No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		nerican Indian, lite, etc. White
o 2	natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	oation during most of work d)	ing I	16b. Kind of Busines	ss/Industry
d Z I Z I	than the man	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire memaker	d)		Own	Home
i ed	Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		110	memarer	18. Mother's Nam	e (First, Middle,	Maiden Surname)	nome
Id be	denta rked tic ev	To B	Daniel J. D'Ambro	osio			Elizabe	th E. Ma	strorocco	
, Maryla and 2 should	alth and I 27 is ma er trauma	ľ	19a. Informant's Name/Relationship (*Kathleen A. Will:						r, City or Town, State Spring, M	
Pages 1.	Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 Barrial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, crer Gate of	sition (Name of matory or other place Heaven Ce		Oct. 30 2009	20c. Location - City of Silver Sp	or Town, State ring, Maryland
Dallino permit. Pages	Departr Imports any inju		21. Signature of Funeral Service Licen	See	4.7	2. Name and Addre Francis 3 500 Unive	J. Collin	s Funera	al Home In Silver Sp	c. ring, MD 2090
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the						Approximate Interval Between
1	nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Acute Myo		Infarctio	n			Onset and Death minutes
	kanniei	e.	Sequentially list conditions, if any, leading to immediate	b	consequence of):					
cuted	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
50 / 5U, ficate be executed	physician and the burial-transit	l Ex	resulting in death) Last	Due to (or as a c	consequence of):					
ficate be ex	physic the b	edical		.d						
O. DOX of	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to make the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23d. Date of o Month						
s that	ned by a deta	by Phy	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
serinbe.	en sig ould b							1 🗆 Y	es 2∐ANo 3∏	Probably 4 Unknown
The law re	his certificate has be i director, page 2 sh	Completed						24a. Was a autops perfor 1 □ Yes	sy prior t med? death	autopsy findings available o completion of cause of ? es 2 □No
VILC	certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		oth	26. Place of Deat			
5 g	er this eral dil	2:10	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time o	N 3 LI DOA	4 LI Nursing Ho		ence 6 Other (S	pecify)
g ig	ath. r: Afte ie fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	/ear) Injury	f 28c. Injui Wor M 1 🗆	kí?]Yes 2 □No		. ,	
al or Atte	s after de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
ne Hospit	in 24 hour he Funera pletely fille	Medical (29a, Certifier ↑ Ĉ CertifyIng Ph (Check only one) 2 Medical Exam	ysician: To the best of piner: On the basis of each and manner state	xamination and/or in	h occurred at the ti vestigation, in my o	ime, date and place opinion, death occur	and due to the orred at the time, or	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To	with.	ž	29b. Signature and title of certific			29c. Licens	se number	2	29d. Date signed (Mo	nth, Day, Year)
	30		1 1266	Korest	an		D09834	(October 26	, 2009
,	!		30. Name and address of person who Barry Rosenbaum,	MD 3720	Farragut		Kensingto	n, MD 20	0895	
	Sta Registr		31. Date filed (Month, Day, Year)			N. S.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28a&f, perME g897 11/18/09 TITUTE of Health and Mental Hygiene 2009 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death lut zler Physician/ Bolland Month)Ave 1400 M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 331 LASASENA iverside Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Davs Hours Min. 232-06-4991 50 8/977 1959 WESTYVVIRGINIA Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ANNE ARUNDEL MD PASADENA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 331 RIVERSIDE DRIVE 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

OWNER 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) DRIVING SCHOOL Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
GOLDIE EDWARDS ٥ CARROLL C. HUTZLER 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 MOORE AVE., MOUNT KISCO, NY 10549 DANIELLE HUTZLER/DAUGHTER Baltimore, Method of Disposition

1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOV. 4 GERRAPOSTONO PRESBYTERIAN CEMETERY GERRARDSTOWN, WV 4 Donation 5 Other (Specify) 2009 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, W 25402 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 35 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown signed by the a Yes g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has After this certificate 25. Was case referred to medical examiner?
1 Yes 2 □ No the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify, Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury UKKM 1 Natural 5 Pending Fd 40/28709 death. 1 Yes 2 No Accident Investigation 24 hours after deat Puneral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Strt. t and Number Phy or Town, State) 331 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) r or Rural Route Number, Riverside Dr. determined Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number Vienuty 29d. Date signed (Month. e and address of person who comple ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regis State NOV Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** $1:04 a^{M}$ October 24, 2009 Virginia Mary Lott /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Germantow..

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
Jan. 8, Montgomery 23120 Bank Barn Court 9. Birthplace (State or Foreign Country) Wisconsin 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 21 1 □ M 2 🕇 F 388-14-6006 88 Director Usual Residence of Decedent 10d. Inside City Limits death with the Marylan 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shov 28a-f shov 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 3370 Chiswick Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates Specify: Specify: ģ White 3 Widowed 4 □ Divorced "natural" Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Contract Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur J. Reifenstuhl Clarissa Fiene ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong. 23120 Bank Barn Court, Germantown, MD 20875 Candace Dowling/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Oct. 30 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>6</u> Arteriosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes after death.

Director: After this certific

in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide filled in 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp within 24 ho To the Fund completely f (Check only manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D08381 October 26, 2009 0 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Benjamih Avrunin, MD 18111 Prince Philip Drive, Olney, MD 20832 27 2009 32. Registrar's Signature State Registrar

Box 68760. P.O. Division of Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed this certificate has To the Hospital v. within 24 hours after death.

To the Funeral Director: Af

> State Registrar

Medical

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

1🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33700

28c. Injury at Work?

1 ☐ Yes

2 🗆 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2009

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

STREET. WILLIAMEPOR HISO 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9903 5-5-10 vt
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar 35914 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Theodoro V. Lemberos Theodora V. Lemberos 2009 11:32P M October 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery Examiner 4b. City, Town, or Location of Death Wheaton 11603 Viers Mill Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24. 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TxF Min. Months Days Hours Director 217-42-3265 76 G<u>reece</u> 933 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 □ No Wheaton Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20902 11603 Viers Mill Road United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces2 1 ☐ Yes 2 ☐ No Black, White, etc. à 1 Never Married 2 X Married 1 Yes : 72 hours after Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Caucasian "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Food Bakery Clerk 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugenia Heon Nicholas Vroustouris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20904 13602 Colefair Drive, Nick Lemberos - Son Baltimore, 1 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD 10/26/2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nirator disease or condition ∤ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ned by the a P.O. | signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s has autopsy performed? death? certificate 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 🗌 Yes 2 🗀 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

3

Sonal Dineshbhai Patel,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifie

M.D.,

Registrar's Signaure

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5766 E. Jefferson Dr.,

29c. License number

29d. Date signed (Month, Day, Year)

20852

Rockville.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#5 Per FH G898 12/07/09JH
State of Maryland / Department of Health and Mental Hygiene

amend #5&9 Per FH G89812/18/09 of Death

Reg. No. 2 1 9 State
 Registrar Reg. No 2 1 1 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 20, 2009 11:17 AM Constance Sheronda Lyons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital 8. Date of Bits Oct. 14, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 T F Days Hours Min. *"*1975 South Carolina 34 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20735 9106 Pine View Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗗 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African ģ 1³∑ Never Married 2 ☐ Married 1 ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify. Specify: American Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) years Cashier Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Yvonne J. Snipe Cederick Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15024 Laurel Oaks Lane Laurel, MD 20707 JoAnn Poindexter - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Oct. 30, 2009 Clinton, MD ☐ Donation 5 ☐ Other (Specity) f Eune al Service, icense SIL 22. Name and Address of Facility aftike Stewart Funeral Home, Inc. NO K 20019 4001 Benning Road, NE Washington, DC23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequent MUNDOSFICIENCY SYMMONE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine e to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Be 2**)** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes မ 1🔀 Inpatient 2 🗌 ER/Outpatient 3 🗍 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury work? 5 Pending 2 🗌 No death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c, License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) OR 2 M.D. 120 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 25, 2009 **Physician** 1:42 a M Leilani Morrison McKenna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3104 Birchtree Lane Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | DeC. 26, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1947 214-50-5470 1 □ M 2 🕱 F Pennsylvania 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. An article Hygiene. The marked other than "natural", or items 23a or 28a-f show any or other traumatic event, its Medical Expenses rule be notified at my or other traumatic event, its Medical Expenses. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Montgomery Maryland Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 Birchtree Lane 20906 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Litigation Support Specialist Department of Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman Morrison Katherine Nemeth ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Kelly McKenna/Husband Birchtree Lane, Silver Spring, MD 20906 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages
Department of Important: If Its
any injury or o 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Oct. 26 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 augus 9 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer less than 1 /Medical Due to (or as a consequence of) year **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): r Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit Exami Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day signed by the ar 5 ☐ Other (specify) 1 □Yes 2 🛛 No o 9 Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Lirector: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35996 October 26, 2009 30. Name and address of person when impleted cause of death (Item 23a) (Type, Print) 2730 University Blvd. W., #400, Wheaton, MD 20902 Linda Burrell, MD 31. Date filed (Month, Day, Year) 82-Registrar's Signature State 27 Registrar

Amend Items 25,27,28a-f per the good place Indelible by 1252646 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 23aPt1, per dr., g899,0172872010dhb

Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Mouynivone 07 omchit 11:31 PM 21. 10. /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner riverity of Maryland Medical Center almore aty 9. Birthplace (State or Foreign Country)
LAOS ial Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours 70 Director 138-70-7691 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Widical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No SUSSEX DELAWARE FRANKFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35722 PINE CONE LANE 19945 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify <u>ک</u> Specify: ASIAN 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LINE WORKER POULTRY PLANT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNKNOWN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 CHIENG MOUYNIVONG/HUSBAND 35722 PINE CONE LANE, FRANKFORD, DELAWARE. 19945 permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra 27 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 R
4 Donation 5 Other specify) 3 Removal from State MELSONS CREMATORY 10/31/2009 FRANKFORD, DELAWARE 21. Signature of Funeral Ser 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD 43 THATCHER STREET, FRANKFORD, DE. 19945 23a. Part 1. Effect the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final U Physician molancity disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Fresh Frozen Plasma CH TENTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-trar Due to (or as a consequence of). Records, P.O. Box 68760, Multi-organ failure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Fibrillationen 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed supra theraputic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred
Anaphylactic reaction s/p 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 10/21/2009 Unknown M 1 ☐ Yes 2 No administration of plasma 24 hours after deat Funeral Director: filled in by the ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 22 S. Greene Street determined 4 Homicide Baltimore, MD Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1205061322 10.22.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Semhar TEWELDE BA2 Street Baltimore MD 201 reen H 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 11:00 p_M 2009 MAUREEN LOUISE MURPHY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S 1509 JOMER DRIVE FORT WASHINGTON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours (Month, Day, Year 4/28/194] **Director** Washington, DC 68 578-56- 5858 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyYes 2 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1509 Jomer Drive 20744 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 K No Specify Page 1 and 2 should be filed within 72 hours aft nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Computer Specialist</u> D.C. Goverment Be 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) other traumatic Cleora L. Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Jomar Dr. Ft. Washington, Md. Curtis Murphy / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Ft.Lincoln 10/26/09 Brentwood, Md. 21. Signature of Funeral Service Lice 2. Name and Address of Facility Alexander S. P 5538 Marlboro Pope P.A. Pikė/Forėstville, Md. 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Ether Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exam requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the bunal Physician/Medical Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown of Vital Records, P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension 1 Yes 2 No 3 Probably 4 L Unknown Completed page 2 should peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbf{X}\) Residence 6 \(\sum \) Other (Specify) 1 X Yes 2 \square No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After this of funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' Division n 24 hours after death.

Reference All Director: All pleted filled in by the fu death. 1 🔲 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical

State Registrar

within 2.

29a. Certifier

only one) 29b. Signature and itle of certific

> 10403 Hospital Dr. G-06 Clinton, Md. Ali Rahimian, M.D. 32. Regis ar's Sig at 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0052999

29d. Date signed (Month, Day, Year) October 24, 2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State of Maryland / Departm. Registrar Certific	ent of Health and ate of Death		giene Reg. No. 2009	35919
	Physic	cian	Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
	/Med		Charles Frederick Madigan		Month October	Day Year 23, 2009	5:38 a M
	Exam	iner	,	city, Town, or Location of Deat	h	4c. County of Death	
	Funera			koma Park . nder i Year If Under 24 Hrs.	To be to	Montgomery	
	Directo		231–36–7752 1 ☑ M 2 ☐ F 73 Yrs. Mont		(Month, Day	(Year) Cou	place (State or Foreign intry)
	pun *		Usual Residence of Decedent		12-2-19	Clark	sburg, WV
	f sho	ō	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	ith the Marylan or 28a-f show	Director	MD Prince Georges Greenbelt 10e. Street and Number				1 1 Yes 2 □ No
	th with 23a or	Ö	8645 Greenbelt Rd. Unit 102 2	Zip Code	1	0g. Citizen of What Cou	ntry?
	items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	0770	U1	nited States	
Baltimore, Maryland 21215-0036	urs aff	þ	3 Widowed 4 Divorced Vegs or Dates: 7 (20 / 5 -	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
5-(72 hours "natural"	Be Completed	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of	sual Occupation		16b. Kind of Business/In	dustry
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d 2	filed Hygi Sther	ပို	12 Elevato	or Inspector		Federal Gov	ernment
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ar∠	should I and Men s marke		Building	Geraldi ess (Street and Number or Ru		11ins	
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ore	Pages 1 nent of H int: If iten iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (No cemetery, crematory or	lame of		20c. Location - City or To	
Ħ.	tment tant:		4□Donation 5□Other (Specify) Fort Lincoln	Cemetery 10-	28-2009 1	Rrontwood 1	MD
Baj	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any Injury or other traumatic event, the "sections once."		21. Signature of Funeral Service Zicensee 7 22. Name	and Address of Facility Fo	rt Linco	In Funeral 1	Home
	202 0 0		3401	Bladensburg Ro	1 Brentwo	od MD 2072	2
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	Physician /Medical		disease or condition resulting in death) a. Chiggsup 1	least La	ilure	/	Onset and Death
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. Box	death ce e attendii d for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic in the past 12 months?			23d. Date of delive Month	ry Day Year
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	es tha gned se del	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
Division of Vital Records,	w requires that the dispersion is been signed by the should be detached	ted				2 No 3 Proba	No.
ec	as 2	Completed			24a. Was an	24b. Were autop	sy findings available
alF	: The cate h	ပ္ပြ			autopsy performe	prior to com death?	pletion of cause of
VIE	sician: The certificate rector, pag	B	25. Was case referred to medical examiner?	26. Place of Death		No 1 □Yes	2 □No
of	ding Physician: The n. After this certificate hi funeral director, page	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Do 27. Manner of Death 28a Date of Journal 28b Time of		ne 5 Residence	ce 6 ☐ Other (Specify)	
on	Attending Physician: or death. ector: After this certifica by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 1 Accident M	AAOIK!	8d. Describe how	injury occurred	
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Ö	tal or s afte al Dir	Serie	4 Homicide determined building, etc. (Specify)	y, office	City or Town, S	et and Number or Rural State)	Route Number,
	Hospital 24 hours Funeral I		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred 1 ★ Certifying Physician: To the best of my knowledge, death occurred 2 ★ Medical Examiner: On the basis of examination and/or invention to the basis of examination and/or invention to the basis of examination and/or invention to the basis of examination and/or invention to the basis of my knowledge.	at the time, date and place, a	and due to the cau	ise(s) and manner as sta	ited
	the the	Medical	and manner stated.	n, in my opinion, death occurre	ed at the time, date	and place, and due to t	he cause(s)
	5 o o	2 2	29b. Signature and title of certifier	c. License number	29d	. Date signed (Month, Da	ay, Year)
	_		regenu, nu	65780	1	0/23/09	
R	.5	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ain of	10	0001	D
	Stat	3	31. Date filed (Month, Day, Year) 32. Registrar's Signature	me la	kma	park, 1	70
	Registra		OCT 2 7 2009 Beneva D. Jakes				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35920 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4.50 PM Kave O'Neal OC+ 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12424 Rays Drive, SE Cumberland Allegany Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 22, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. Director 214-42-0181 66 1943 MD Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b Count 10c. City, Town or Location 28a-f show 27 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Exeminating the nutting at MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 12424 Rays Drive, SE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after cleatth and Mental Hygiene. m 27 is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CNA Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Ullery Ilda Shanholtz Ullerv P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert O'Neal 12424 Rays Drive, SE husband MD 21502 item 27 i Cumberland Pages 1 grant of H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal Rocky Gap Veterans Cemetery 11/3/2009 Flintstone MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funer Service Linenseé 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death): **Physician** Imphoma /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deat

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 □ No 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of cert

UNIL

31. Date filed (Month, Day, Yea NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

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32. Registrar's Signature

GUPTA,

Year)

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CUMBERLAND, MD 2150

State of Maryland / Department of Health and Mental Hygiene, Reg. No 2009 35921 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 100 - 15 - 2009 Eddie Lee Prince 1:31 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 0 7 0 7 7 9. Birthplace (State or Foreign S. & Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F Hours Min. 1936 73 Director 579468758 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at District Height's P.G. MD 1⊠Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? USA 20747 6307 District Heights Parkway 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 ™ No If Yes, Give Year or Dates! 955–59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ SpecifyBlack 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent the second Elementary/Secondary (0-12) College (1-4or 5+) Sound and Video Tech. NBC 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Lou Price Willie Pearl Prince 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 0747 19a. Informant's Name/Relationship (Type. Print) Olivia Prince/wife 6307 District Heights PKWY, Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 TBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 10/23/09 Cheltenham, MD Vetrans CEM. 21. Signature of Funeral Service Licensee 420 H St.NE. 22. Name and Address of Facility B.K. Henry Funeral Home Wash.DC.20002 tenu 23a. Do 1. It ter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespiratory TailVRE **Physician** disease or condition resulting in death) /Medical Obstructive Pulmonory Disense Examiner Sequentially flat corruitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 □No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number DOOG 1172 30. Name and address of person who completed cause of death (Item 23a) (Type 3001 Hospital Dr. Cheverly Md. KONWIE 31. Date filed (Month, Day, Year) State OCT 27 Registrar

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Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROSENBERG BLANKA October 2009 6:10A Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Examiner .. County of Death Montgomery Silver Spring 920 Hyde Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 1 F 91 123-32-3778 Director Czechoslovakia 1918 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of Americ 20902 902 Lamberton Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces Black White etc. 1 Never Married 2 Married δ Yes 2X No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates Caucasian the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) $\overset{\text{Elementary/Seconday (0-12)}}{12}$ College (1-4 or 5+) Garment Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sofia Eisenstadter Josef Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is MD 20902 920 Hyde Road Silver Spring, Eva Moskowitz- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/28/2009 Jerusalem, Israel Har Menuchot 21. Signature of Faneral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Pretand Beath Filysician/ Breast Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death 2X No 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 X No 1 Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\to\) Nursing Home 5 \(\to\) Residence 6 \(\tilde{\textbf{X}}\) Other (Specify) Residence 2 [XNo 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 6

Registrar

5454 Wisconsin Ave., Suite 1300, Chevy Chase, MD20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Nelson Gustavo Kalil,

State of Maryland / Department of Health and Mental Hygiene 35923 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 25, Day 2009 Physician Year Concepcion M. Rivas 7:02 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2023 F Director 219-96-6892 85 April 6, 1924 El Salvador Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Montgomery 1 ☐ Yes 2 XNo Rockyri 11a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5811 Vandegrift Avenue 20851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 TxYes 2 □ No ģ If Yes, Give Year or Dates Specify: Salvadorean White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' filed within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Silvestre Rivas Isabel Melendez 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose Guzman/Son 5811 Vandegrift Avenue, Rockville, MD 20851 Department of Health Important: If Item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October 29 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Renal Failure /Medical Due to (or as a consequence of) Examiner Obstructive Sleep Apnea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of law requires that the death certificate be executed Morbid Obesity the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Year Day 5 ☐ Other (specify) Ö the detached 9 Unknown þ ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Hyponatremia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy The page certificate 1 ☐ Yes 2 **X**No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 XNo 1 Manatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation hours after death. uneral Director: Af ely filled in by the fur 1 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 October 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garq, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 27 OCT

DHMH 17 Rev 1/2001

Registrar

09-08461 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 35924 State of Maryland / Department of Health and Mental Hygiene Paul Christopher Rodola 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Time of Death Physician/ Month Day November 1, 2009 Rodola 0400 hrs Christopher Paul **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Howard If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Min Director 548-55-8559 1 X M 2 F 1975 Country) Oct 11, Yrs 34 MD Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 X No Howard Elkridge notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 6513 New Castle Lane uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes Œ Specify: White 4 X Divorced Yes 2 X No specify: 3 Widowed If Yes, Give Year the Medical Examinar ₽ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 hours Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvements Painter 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan Ann Frizzell Be Robert Austin Rodola Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ent of Health and M nt: If item 27 is ma Joan A. Rodola/mother 6513 New Castle Lane Elkridge, MD 21075 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Final Journey Crematory 11/03/09 tant: or ot Woodbine, MD Donation 5 Other Specify 22. Name and Address of Facility Columbia Mortuary Service, M00969 9013 Annapolis Rd. Lanham, nature of Funeral Service License MD art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Narcotic (heroin) intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED **AMENDED** attending physician or use as the burial 23a,27,28a-f,permE, g897 11/24/09 TT 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Vital Be examiner? Other 4 Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 ER/Outpatient 3 Other 1 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Division Natural Yes 2 X No Pending Director: unk 11/1/09 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide 8300 Benson Dr Columbia, MD (Specify) restroom Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Sidnature and title of certifie O.C.M.E November 1, 2009 elle

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State Registrar 111 Penn Street, Baltimore, MD 21201

and address of person who complete vuse of death (Item 23a)

Assistant Medical Examiner

Laron Locke MD.

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DHMH 17 Rev 1/2001

within 24 hours a

31. Date filed (Month Registrar's Signature varke

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 2, 2009

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 35927 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Margie Fay Stanton October 24, 2009 3:30 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb. 24, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Year) Hours Min 1 □ M 2 🖾 F Illinois Yrs 341-24-3624 82 1927 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 💆 No Director P.G. Silver Spring Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3160 Gracefield Road, Apt. 1110 20904 USA death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene, 1 Never Married 2 Married 1 □Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. ^{Specify:}White 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Statistician Pages 1 and 2 should be filed vent of Health and Mental Hygint: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marguerite Doty Otto Hartmann other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 14740 Carona Drive, Silver Spring, MD 20905 Michael Drake Stanton/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 26 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 4 Donation 5 Dother (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20902 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year **Physician** Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Box 68760 cate has been signed by the attending physician page 2 should be detached for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) o 9 Unknown 9 Unknown ۵. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Chronic Hepatitis of Uncertain Etiology 1 ☐ Yes 2(X) No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2¥ No 2 1 Npatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division (Month, Day, Year) Injury 1 X Natural 5 Pending investigation he Hospital or Attendii in 24 hours after death. he Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier Fig. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year)
October 26, 2009 29b. Signature and title of co 29c. License number D24093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Mark Parkhurst, MD 31. Date filed (Month, Day, Year) Registrar's Signature State ach OCT 27 2009 Registrar

Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after

d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at

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Physician

/Medical

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Funeral

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Completed

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Baltimore, Maryland 21215-0036 Health em 27 i item 27 other t ò Department of Important: If it any Injury or o once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 1070 HOTO Na Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami the burial-tra Box 68760 Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? P.0. s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, <u>^</u> Completed certificate has triector, page 2 st Division of Vital 25. Was case referred to medical director Be 1⊠Yes 2□No Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending 24 hours after death. Funeral Director: A investigation Oct 18 2009 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide filled in by determined 29a. Certifie completely (Check only one) within 2 To the 29b. Signature and title of certifier 3 LRECHES mo 2 31. Date filed (Month, Day, Year) State

State of Maryland / Department of Health and Mental Hygiene 35928 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day October 18, Vladimir 2009 10:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 106 Booth Street, Apt. #24 Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 7, 1943 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1 X M 2 □ F Russia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🖾 No Kyrgyzstan none Bishkek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 Prospekt Manasa 720014 Kyrgyzstan Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer Correctional Facility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fedor Shabalin S'jomshhikova 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Booth Street, Gaithersburg, MD Anna Shabalina, daughter 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Lincoln Crematory 10/27/2009 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 26. Place of Death (Check only one) Daughter's Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{E}$ Other (Specify) Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 15115 1 ☐ Yes 2 No R (Street and Number or Rural Route Number, own, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town, day 3 hypr's 8651 20874 denie Carthaiston mo Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 2 wo owe D 30478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 1 2 1 medical Dm5 SILVER 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

09-08160 Pablo Serpas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009

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an/ ner	Registrar 1. Decedent's Name Pabl	•	e,Last) Anto					-			2.	Date of De	ath Day	Year	3.	Time of Death
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F.	3 Widowed	4 Divorced If Yes, 2 X No 1 X Yes 2 No specify:										Oran	s	pecify:	MIIT	
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202. Mellid of Disposition Removal from State Resthaven Cer											10/24/2009 Thurmont, Md.					
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in price	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus											e cause(s)				
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1	Cod	ے دے			5.1.10	(Itom 23a)	_			_						
	30. Name and ad	dress of per	son who co	mpleted ca	use of death	(ILOIII 25a)										
ŀ	30. Name and ad				use of death Examine	r 111	Penn	Street, E	Baltim	ore, MI	2120	1				
	Certification: To Be Completed by Physician/Medical Examiner	Usual Residence of 10a. State MD 10e. Street and Nu 1572 Ca 11. Marital Status 1 X Never Marria 3 Widowed 15. Decedent's E Elementary/Sec 10 17. Father's Name JOSE 19a. Informant's N ZOILA E 20a. Method of Dis 1 X Bunia 2 4 Donation 5 21. Signatire of Fi 23a. Part I. Enter 1 failure. List o Immediate Cause or condition result Sequentially list c if any, leading to i cause. Enter Unc (Disease or injury events resulting in UNPENDE: 1 Yes 2 Part II. Other sig 25. Was case ref examiner? 1 Yes 2 Part II. Other sig 25. Was case ref examiner? 27. Manner of De 28. Certifier 1 29a. Certifier 1	10a. State MD Frede 10b. County MD Frede 10c. Street and Number 11c. Street and Number 11c. The street	Usual Residence of Decedent 10a. State MD Frederick 10b. County MD Frederick 10c. Street and Number 1572 Carey Place 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced It Y or 15. Decedent's Education (Specify only in Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last) Jose Felix Ser 19a. Informant's Name/Relationship (Type Zoila Esperanza 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donardon 5 Other Specify: 21. Signalare of Funeral Service Licensee Immediate Cause (Final disease or complica failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that immated events resulting in death) UNPENDED JFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of Could not be determined 27 Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a Certifier 29a Certifier 29a Certifier 29a Certifier 29a Certifier 29a Certifier 29a Certifier 29a Certifier	Usual Residence of Decedent 10a. State 10b. County MD Frederick 10e. Street and Number 1 5 7 2 Carey Place 11. Marital Status 1 X Never Married 2 Married 1 Yes Give Yes 1 1 Yes 1 1 O	Usual Residence of Decedent 10a. State 10b. County 10c. Cit MD Frederick 10b. County 10c. Cit MD Frederick 10b. Street and Number 15.72 Carey Place 11. Marital Status 12. Was Decedent Ever in Armed Forces? 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD Frederick Frederick Frederick 10a. State 10b. County 10c. City, Town of MD Frederick Frederick Frederick 15. Prederick 12 Married 12 Married 12 Married 12 Married 12 Married 13 Widowed 4 Divorced 175e, Give Year of Divorced 175e, Giv	Usual Residence of Decedent 10a. State 10b. County MD Frederick 10c. City, Town or Locat Frederick 10c. Street and Number 1572 Carey Place 11. Marital Status 12 Never Married 2 Married 13 Wildowed 4 Divorced If Yes, Giver Year 15 Decedents Education (Specify only highest grade completed) 15 Decedents Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailin 201 To Jose Felix Serpas 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailin 201 To Jose Felix Serpas 19a. Informant's Name/Relationship (Type, Print) mother 201 To Jose Felix Serpas 20a. Method of Disposition 1	216-61-8820 1 m 2 F 16	Usual Residence of Decedent 106. Courty 106. City, Town or Location 107. Expected 106. Courty 106. Courty 106. City, Town or Location 107. Expected 107. Exp	216 - 61 - 88 20 1x M 2 F 16 16 16 16 16 16 17 17	Special decirity values 1	Usual Residence of Decedent Too. State Too. County To	Supplementable Supplementable Supplementable Supplemental Supplementable Supple	Security National State 10 Security National Residence of December 10 Security National Residence of December 10 Security National Residence of December 10 Security National Residence of December 10 Security National Residence of December 10 Security National Residence of December 10 Security National Residence of Nation	State Security More Stat

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State Registrar 31. Date filed (Month, Day, Year

Registrar's Signatur

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	Physici	an/	1- For State Registrar 1. Decedent's Name (First, Middl	le,Last)	Cer	tificate d	of Death		· · · · · ·		. Date of D			009	3. Time of Death
Med	ical Exami	ner	William 4a. Facility Name (if not institution	John St	weeny		Month Octob 4b. City, Town, or Location of Death						0700 hrs		
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	Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Months	If Under 2	Min		,	ĺ	Cour	place (State or Foreign atry)	
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	MD 21215-0036 d 2 should be filed within 7 Ith and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>	o Be	Elmer Jo 19a. Informant's Name/Relations	ohn Sweeny	7	19b. Maili	ng Address (Street			Dagi			. State.	Zip Code)
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	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after a permit. Pages I and 2 should be filed within 72 hours after a permitten of Health and Mental Hygiera. If them 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 XXcremation	n 3 Removal	from State	crematory or					Date		oc. Location - 0		
	Baltimore, bermit. Pages I at Department of Her important: If ite njury or other tr		4 Donation 5 Other Sp 21. Signature of Funeral Service		L€		natory . Name and Ad			200		ra 1	Clinton	n, M	aryland 633 Old
	Ba perm Dep		Davis X &	hant 1.	000057		Alexan	dri	a Fer	ry	Road	, C1	inton,	MD	20735
	Physician /Medical	1	23a Part I. Enter the disease, or failure. List only one cause	e on each line.								arrest,	shock, or hea	rt	Approximate Interval Between Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death)		osclerot a consequence o		diovas	<u>cul</u>	ar di	sea	se				Dod.ii
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	f):					-				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ç	a consequence o	f):				-					
	ecuted and transit	ਰ		d											
	ਭ ਜ਼ਿਜ਼ ਜ਼ਿਜ਼	ledic	XUNPENDED IF FEMALE:	AMENDED	23a,PII		erme g8	97,	11/2	24/0	9 TT		02d Date of	dolivos	
	ox 68760, ath certificate be ex attending physician or use as the burial	sician/Medic	23b. Was decedent pregnant in the past 12 months?	the 1 Live		2	Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Yes						ay Year		
	Box 68760, e death certificate be the attending physic ed for use as the bur	ysic	1 Yes 2 No 9 Un	knoum	nant at time of de nown	eath 5	Other (Specify) —				-			
	Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u	by Phy	Part II. Other significant condit		to death but not r	esulting in the	e underlying ca	use gi	ven in Part	; I.				_	ne cause of death?
	rds, requires been sig	Completed	Cocaine	use						_	24a. V	Vas an	24b. W	/ere auto	opsy findings available
	tal Records rian: The law requi certificate has been ector, page 2 should	dmo								_	P	utopsy erforme es 2	d? d	eath?	ompletion of cause of
	Vital R ysician: 1 his certific director, p	Be C	25. Was case referred to medica examiner?			-			of Death (C	Check or	nly one)				
	n of Viding Physical After this funeral directions	၉	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 e of Injury	ER/Outpatie			Other ₄		Home 5		sidence 6 v		Scene
	Sion (Attending death. ctor: Af	Certification:	1 X Natural 5 Pen	(Mon	th, Day,Year)		1	Y	es 2 N	No					
	Division of Vital Records, ran or Attending Physician: The law requiring a start death. In Director: After this certificate has been sited in by the funeral director, page 2 should the	3 Suicide 6 Cou	ome, farm, st	me, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Nor Town, State)						al Route Number, City					
son to the state of the state o											d.				
	To the within To the comple	Medical	one) 2 Medical Exa 29b. Signature and title of certific	aminer: On the basis		and/or investig				urred at	the time,				
		-	255. Signature and title of certific	land	\			D.C.N	number A.E.				^{9d.} Date signe October 27	,	
			30 Name and address of person												
		ate	Laron Locke MD. A 31. Date filed (Month, Day, Year)	Assistant Medic	al Examiner Registrar's Signati		nn Street, B	altim	nore, MD	2120)1				
	د Regis		NOV 0 9 20	009 Sero	va A.	part									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Armethia Sharp 2009 October 20, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 455-64-9940 71 Director 1938 Texas April 10, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at 1 Yes 2 □ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 2002 Avalon Place United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. African 1 ₩ Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: American Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Custodial Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leo Sharp Mavy Lee ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 Is any Injury or other trau Faith R. Sharp - Daughter 2002 Avalon Place Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Oct. 27, 2009 Ft. Brentwood, MD Eune 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Endometrial Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Examir burial-transit Pneumonia and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Pulmonary Embolism Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66162 October 21, 2009

Registrar

State

CR 10

1500 Forest Glen Road Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Edith Aniedobe

31. Date filed (Month, Day, Yea, OCT 2 7 2009

		1	For State of Maryland / Dep Registrer	artment of Health and Me rtificate of Death	Reg. No.	09 35933
	Physicia	ın	I. Decedent's Name (First, Middle, Last) Michael Glavaski		Date of Death Month Ct. 25	3. Time of Death 4:04 A M
À	/Medic Examin		la. Facility Name (If not institution, give street and number) 9404 Bac Place	4b. City, Town, or Location of Death Gaithersburg		y of Death tgomery
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $032-42-4462$ 1\$\overline{1}	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. J	Date of Birth (Month, Day, Year) an. 29, 1932	9. Birthplace (State or Foreign Country) Yugoslavia
	with the Maryland se or 28e-f show the natified at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Montgomery Gaith 10e. Street and Number 9404 Bac Place	ersburg 10f. Zip Code 20877		10d. Inside City Limits 1 □ Yes 2 No What Country? U.S.A.
Maryland 21215-0036	ould be filled within 72 hours after death with the Maryland Mental Hygiene. Amental Hygiene. Amental Hygiene. Amental Hygiene. Amental Hygiene. Amental Hygiene.	by Fur	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec (ifiv. (ifiv. (ifiv. Ifiv.	Was Decedent of Hispanic Origin? (Specifl Yes, specifly Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specifly: edent's Usual Occupation by Not Wes retired) by Not use retired)	Spec	ace - American Indian, ack, White, etc. ify: White Business/Industry
212	led withii lygiene. her than nt, It a M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ 17. Father's Name (First, Middle, Last)	Research Chemist	U.S. First, Middle, Maiden Suma	Government
/land	uld be fi Mental H irked ot itic ever	To Be	Trifun Simic		Smiljka Glav	vaski
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Branchatt. If them 27 is marked other than "netural", or liems 23e or 28e-f show any injury or other traumatic event, the Modical Examination ust be notified at once.		Karen Taylor (wife) 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fineral Science Licens		tersburg, MD te 20c. Location (0) Libert	20877 n - City or Town, State yville, IL
8760,	death certificate be executed Again to a standing physician and a sa the burial-transit and for use as the burial-transit and the same as	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart faiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		respiratory arrest,	Approximate Interval Between Onset and Death
P.O. Box 6	the death certiff y the attending ched for use as	Physician/Med		□ □Ectopic pregnancy □ □ Other (specify)		Date of delivery Month Day Year
	es pi	þ	Part II. Other significant conditions contributing to death but not resulting in the Cerebral Vascular Accident	underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records,	The law requires ate has been sign page 2 should be	Completed	Atheroscerotic Disease		24a. Was an 24 autopsy performed? 1 Yes 256 No	b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)
Vital	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 Nursing Hor		Other (Specify)
ou of	Phys rthis raldi	tion; To	1 Yes 2 No 103 Natural 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 2	8d. Describe how injury occ	
Divisi	f or Attending after death. Director: Afte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	8f. Location (Street and Nu City or Town, State)	imber or Rural Route Number,
	To the Hospital or Atter within 24 hours after de To the Funerel Directo completely filled in by tt	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	nd due to the cause(s) and od at the time, date and place	manner as stated. ce, and due to the cause(s)
•	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		gned (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type 23a) (Type 23a)			26, 2009 2 <i>R</i> (5
	•	ate rar	31. Date filed (Month, Day, Year) OCT 2 7 2009 Denum A. Signature	ne. Suite 700 Chery	VIUS INLY	N-11-

DHMH 17 Rev 1/2001

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State

Registrar

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South

32. Registrar's Signature

pour

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SZE TO

WINNIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35935 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct D**o**y Franklin H. Samuel 2009 0150 Ам Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Days 69 054-32-4651 6/12/1940 Director Usual Residence of Decedent shov 10a. State MD Montgomery with the Maryland notified at 10c. City, Town or Location Director 10d, Inside City Limits 28a-f Rockville 1X Yes 2 No 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 20853 USA 14317 Briarwood Terrace 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 X Married unk \$ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Completed . Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) social work Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rose Sklou ည Max Samuel 19a. Informant's Name/Relationship (Type, Print)
Rene P. Samue I -- Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 14317 Briarwood Ter., Rockville MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Nonald Wade per DVR 22. Name and Address of Facility State Anatomy Board 655 W Baltimore St., Baltimore MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Acute Renal Failure Medical Due to (or as a consequence of) Examiner Electrolyte Abnormality Exquentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Hyperkalemia s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has I funeral director, page 2 s autopsy performe death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 K Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours af Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contributing Nursic Frantianier: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 3 inly and)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 09

32. Registra's Signature

Dr. Alan Schneider, 10313 Georgia Ave., #306, Silver Spring MD 20902

29c. License number

D40611

29d. Date ≴igned (Month, Day, Year)

09

09-Jet

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-08526 ffrey Travers	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	. 2009 3590
Physician/	Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day	3. Time of Death
edical Examiner		c. County of Death
	2326 Hoopers Island Fishing Creek	Dorchester
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM Months Days Hours Min. June 30,	(VDD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
nd show any ice.	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 Yes 2 XNo
the Maryland a or 28a-f show iffed at once. Director	10e. Street and Number 10f. Zip Code 21634	tizen of What Country? USA
hours after death with the Maryland hours after death with the Maryland waturalt", or items 23a or 28a-f she Examiner must be notified at once ited by Funeral Director	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No. No. Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. white Specify:
n "natural"; al Examine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry
ical ical	Elementary/Secondary (0-12) College (1-4 or 5+) maintenance S	state government
e, MD 21215-0036 I and 2 should be filed within 72 retails and Mental Hygener riem 27 is marked other than " r traumatic event, the Medical I To Be Complet	Riley William Travers Jr.	
b 21, should the and Men 7 is mar To 1	19a. Informant's Name/Relationship (Type, Print) Jeanne Travers 19b. Mailing Address (Street and Number or Rural Route Number, 2326 Hoopers Island Rd., Fishi	ing Creek, MD 21634
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med To Be Comi	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	c. Location - City or Town, State Cambridge, MD
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Fune	ral Home P.A.
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s	MD 21613 shock, or heart Approximate Interval Between Onset and
Physician 'Medical caminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hydrocodone and zolpidem (Ambien) intoxication of condition resulting in death) Due to (or as a consequence of):	Death
à	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
K 6876 n certificat ending ph use as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month Day Year
P.O. Bc es that the dea igned by the a detached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact 1 Yes 2	co use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. Boy Isl or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the attention by the first of th	24a. Was an autopsy performe 1 ✓ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
al Re an: The ertificat	25. Was case referred to medical	sidence 6 V Other: Scene
of Vita Physicia ter this ce eral direc	1 V Yes 2 No The patient 2 Exceptation 28d, Describe how 28d	vinjury occurred on
ivision contraction or Attending after death. Director: Aftin by the fun	1 Natural 5 Pending Ed 11/3/09 ED 0803 hrs 1 Yes 2 No drugs	set and Number or Rural Route Number, Cit e)2326 Hoopers Island
Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	3 Suicide 6 Could not be determined (Specify) residence Fishing (creek, no
Dine Hospital		s) and manner as stated. d place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier 29c. License number	9d. Date signed <i>(Month, Day,Year)</i> November 4, 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

			ertificate of Death		2009 35937						
Physic /Med		1. Decedent's Name (First, Middle, Last) James Albert Thompson			Day Year 3. Time of Death 20, 2009 8:11 P						
Exami	iner	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Dea Silver Spring	th	4c. County of Death Montgomery						
Funera Directo		5. Social Security Number 6. Sex 1	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min								
ne Maryland 8a-f show	ector	10a. State 10b. County 10c. City, Town or Maryland Prince George's Capito	1 Heights		10d. Inside City Limits ★☐Yes 2 ☐ No						
3a or 2	al Dire	10e. Street and Number 924 Balboa Avenue	10f. Zip Code 20743	100	Drited States						
DEFILITION E. INTERTY FACE A 2-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant and Invitined at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3	. Was Decedent of Hispanic Origin? (: IfYes, specify Cuban, Mexican, Puer 1 □ Yes 2√2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. African Specify: American						
within 72 ho ene. than "natur	Completed	(Specify only highest grade completed) (Given the specific of	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) borer	rking 16	b. Kind of Business/Industry Private						
na c e filed at Hygi l other vent, I	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Ma							
yiand nould be file if Mental Hi narked oth	To	Albert Thompson		e Overbey							
Man nd 2 st alth and 27 Is n r traum	I		lling Address (Street and Number or R Memory Lane Silve								
DallIIIIOre, bermit. Pages 1 ar Department of Hec mportant: If item any injury or othe			position (Name of ematory or other place)		c. Location - City or Town, State						
it. Pag irtment irtment irtant: njury		4 Donation 5 □ Other (Specify) Fort Line	coln Cemetery, Oc	t. 28, 200	9 Brentwood, MD						
Departiment of the portion of the po			4001 Benning Road								
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hysician: The law re this certificate has be all director, page 2 sho	Completed			24a. Was an autopsy performe 1 ⊡Yes 🏽 🏖							
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_ pn _p _e		27. Manner of Death 1 X Natural 5 Pending 2 Accident Accident Season 28a. Date of Injury (Month, Day, Year) 28b. Time Injury		28d. Describe how							
tal or Att rs after d al Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)						
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical (29a. Certifier (Check only one) **X**CertifyIng Physician: To the best of my knowledge, de: 2 Medical Examiner: On the basis of examination and/or and phoner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)						
To the com	Ž	29b. Signature and title of certifier	29c. License number	i	. Date signed (Month, Day, Year)						
2		30. Name and address of person who completed cause of death (Item 23a) (Type	D09834	0	ctober 21, 2009						
n-		Barry Rosenbaom, M.D. 3720 Farrage	ot Avenue Kensingt	on, MD 20	895						
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State Registrar Cert	tificate of Deal			··· 2009	35938			
	Physici	an	1. Decedent's Name (First, Middle, Last) Ralph Alexander Taylor		1		Day Year	3. Time of Death			
	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locati		October 1	c. County of Death	5:10 A M			
age of the same	Funeral	Н	Sarah's Place - Heartland Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clinton If Under 1 Year If Uni	nder 24 Hrs.	8. Date of Birth	Prince Ge	_			
	Director		051-48-5503 ¹\\ M № 2□ F 86 Yrs.	Months Days Hou		8. Date of Birth (Month, Day, Yea		place (State or Foreign ontry) oados			
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		_	1	0d. Inside City Limits			
	he Mar 28a-f s	ector	Maryland Prince George's Clinton	1401 791 0			1 √ Yes 2 No				
	h with t	al Dir	3407 Accolade Drive	10f. Zip Code 20735			Citizen of What Cour United Sta	*			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Exaction must be 1 officed at once.	by Funeral Director	1 Never Married 2 Married 1 TYes 2 TNo	las Decedent of Hispanic Yes, specify Cuban, Mex ☐Yes 2 \ No Spec		cify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:				
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land	uld be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) James Taylor			(First, Middle, Maid Drayton	en Surname)				
Mar	id 2 sho Ith and 27 is m		//	Address (Street and Nu. B Jenkins Ri							
Baltimore, Maryland 21215-0036	Pages 1 and 2 arent of Health a ut; If item 27 is ry or other trau		20a. Method of Disposition 20b. Place of Disposition cemetery, creme		Da		Location - City or To	own, State			
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service cells 22.	Name and Address of Fa	. 50		neral Home				
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ion o	Attending Physician: sr death. ector: After this certific by the funeral director, I	ation: T	27. Manner of Death 1 🕱 Natural 5 Dending (Month, Day, Year) 2 Daccident investigation 28a. Date of Injury (Month, Day, Year)	28c. Injury at Work? M 1 Yes 2	28	d. Describe how inj		у повртсе			
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	Vithir Comp	Me	29b. Signature and title of certifier	29c. License numbe		29d. C	Date signed (Month, october 22	Day, Year) 2009			
R	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr George Bone, M.D. 1100 Mercantile La	int) ane #135 Lar	rgo, MD	20774					
	Sta Registra	.~	31. Date filed (Month, Day, Year) OCT 2 7 2009 Grand J. Registrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TORO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TRUNDAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 🗶 F Months Days Hours Min. Maryland 77 Director 216-28-2521 1931 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Pasadena Anne Arundel MD 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 8407 Bay Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc ō ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Anne Arundel County (Give kind of work done during most of working filed within 72 tal Hygiene. d other than " life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Police Department Crossing Guard permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pasquale Bonizio Josephine Grazapline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark J. Von Sas / Son 8407 Bay Road Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sacred of Heart of other place) Jesus Cemetery Oct. 2:009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee P.A. Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral H Severna Park, MD 21146 23a. Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ ADVANC YPAR disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year 1 ☐ Yes 2 g ☐ Unknown the a Unknown P.O. completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confloute to the cause of death? Deperssion Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes PCRTONSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death. Funeral Director: After this certificate has performe 2 No 1 Tes 25. Was case referred to medical examiner? Division of Vital Be (26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar DHMH 17 Rev 7/2009

within 2

29b. Signature and title of certifier

31. Date filed (Month, Day,

daddress of person who completed cause of death (Item 23a) (T

			For State Registrar		State of I	vlarylan	id / Depa Cer	artment of I tificate of I	Health a Death	and Mer	ıtal Hyç	giene Reg. No	200	3	35940
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 24a per phys. G898 12/1/09 dk. State of Maryland / Department of Health and Mental Hygien 2 0 0 9 3594 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 Jean F. West 10:50 PM 24 Oct. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 227 Porters Bridge Rd Colora Ceci1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours Min. 216-24-7108 10, 1928 81 Aug. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Porters Bridge Rd. 21917 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛛 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Benton Felty Mary F. Kirk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Holbrook/Daughter 227 Porters Bridge Rd., Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Brookview Cemetery 4 Donation 5 Dother (Specify) 10-29-2009 Rising Sun, Maryland 21. Signature of Foneral Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD schara 21911 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, in heart failure. List only one cause of each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 2 heimers Due to (or as a consequence of): Sequentially list conditions Due to (or sele consequence of) dry, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 ⊠No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner Examine and burial-trar Physician/Medical

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If ttem 27 is marked other any injury or other traumatic event, II

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72 hours after death

Baltimore, Maryland 21215-0036

attending physician for use as the buria

IF FEMALE:

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hin 24 hours after death.	the Funeral Director: After this certificate has been signed by the	npletely filled in by the funeral director, page 2 should be detached
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Division of Vital Records, P.O. Box 68760 Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) To Mit To 00023322 Jachder 5 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEV MD 126 A, E King S, Elhan MD 21921. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 7 2009

Registrar

10.26.2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Yo1anda Zeik October 20, 2009 3:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/06/1927 Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 149-50-8250 1 □ M 2 🕱 F Cuba Director 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Weddon Event in the Demonstration MD Rockville Yes 2 No Montgomery 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20852 11602 Split Rail Court Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemany Injury or other traumatic event any logure. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2x☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2× No Specify: White 1XDYes 2□No Specify: Cuban <u>Ş</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hilton Manufacturers Seamstress 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ana Moreno ဂ္ Jose Chediak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11602 Split Rail Court Rockville, MD 20852 Yolanda Albornoz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4 Donation 5 Other (Specify) Entombment Hollywood Mem. Park Union, New Jersey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. Wille 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final artenoscle Physician 1100 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of anding physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant been signed by the atter should be detached for u in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 ☐ Yes 2 1 NK 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 🔲 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No or Attendates death Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

 \sqrt{OLANDA} 10/30/69 15/1sion of Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral I

Registrar

29a. Certifier

(Check only

Medical

29c. License number

29d. Date signed (Month, Day, Year)

revocus Grucheman completed cause of death (Item 23a) (Type, Print) gerouis Ra 8600010

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anders Evald 11/7/2009 Day Aaberg 4:35 AM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore ocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 112-18-6246 Days Hours 87 12/94/1929 Director Sweden Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Fallston 1 🗌 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Chateau Court 21047 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 WII 1 Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Captain Merchant Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nils Aaberg Ida Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Stachurski / Nephew 215 Courtland Avenue Stamford, Connecticut 06906 Baltimore, NOVEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, St. Stanislaus Cem. Donation 5 Other (Specify) 11/11/2009 Raltimore Maryland ignatur of Funeral Service Lb 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease fiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate shock, or heart failure. List on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEVERE PERIPHERAL VASCULAR DISEASE Medical Due to (or as a consequence of Examiner **GANGRENE** Sequentially list conditions, framework to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 1 ☐ Yes ∠ . 9 ☐ Unknown 9 Unknown . P.O. Hospital or Attending Physician: The law requires that the ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? cate has been signed of Vital Records. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 1 Yes 2X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) After this HOSPICE completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of c 29c. License number 29d. Date signed (Month. Day. Year) 009 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and JACKÍE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Andrews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale HOSPHO tranklin Savare ('PMC) Battmore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | February 18,1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1**X** M 2□ F 77 219-28-4314 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Exercity or out by putfill of anone. 1 ☐Yes 2X No Director Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 USA 2207 Frosburg Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 □ ₹es 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ No Specify: Specify: White ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright 12 years Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David William Andrews Grace N. Boice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2207 Frostburg Road, Frostburg, Maryland 21532 Susan A. Sommers Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 12, 2009 Connelly Funeral Home Of Dundalk, P.A. Signature of Funeral Service Licensee nothou 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the dise ase or con shock, or heart failured ist only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** UNKNOWN /Medical Due to (or as a consequence of): Examiner Ulmonary Hype Due to (or as a consequence of): UNKNOWY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician the burial Physician/Medical certificate has been signed by the attending pricector, page 2 should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐ Yes 2☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [] Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this After thi 27. Manher of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation ours after death.
neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Hospital

Baltimore, Maryland 21215-0036

State

FRANKLIN 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SQUARE

Le Harathil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

JOHN

29d. Date signed (Month, Day, Year)

NOVEMBER, 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Diane G. Ailor 6, November 2009 1705 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Nursing Home Denton Caroline 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. 214-70-5941 51 Director 1/14/1958 <u>Delaware</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No Caroline MD Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Kerr Avenue 21629 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ģ Specify Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk Advertising/Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cahall William Ross Virginia Winnie Greeson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Cahall/ Son 314 Railroad Avenue, Goldsboro, MD 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, Maryland Anatomy Gifts Registry 11/10/2009 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition disease or condition resulting in death) renal a, lure Due to (or as a consequence of) hydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami adiation encephalo pat Due to (or as a consequence of): Physician/Medical Cances IF FEMALE F þ Completed 2 Be Certification: To 2

/Medical Examiner Division of Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed burial-trar physician use as the attending p signed by the a certificate has been page 2 funeral director, ours after death.

neral Director; Af
filled in by the fur To the Hospital within 24 hours a To the Funeral E Hospital

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Ire

Physician

Baltimore, Maryland 21215-0036

if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

23b. Was decedent in the past 12 1 ☐ Yes 2 ₹ 9 ☐ Unknown	menths?		23d. Date of delivery Month Day Year				
Part II. Other signif	icant conditions o	ontributing to death but not res	ulting in the underlying	g cause g	ven in Part I.	23e. Did tobacco	to use contribute to the cause of death?
recu	rrent	レイエ				1 □ Yes	2 No 3 Probably 4 donknown
						24a. Was an autopsy performed? 1 □ Yes 2 ☑	
25. Was case referr examiner?	red to medical				26. Place of De	eath (Check only one)	
1 Yes 2 ☑	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Ot	her: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigatio			28b. Time of Injury M	28c. Inju Wo 1 E	ry at rk?]Yes 2 □ No	28d. Describe how in	jury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fact	28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only	1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examina	owledge, death occurration and/or investigati	ed at the ion, in my	ime, date and pla opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

2005325

restan Mi

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

But 136 led num Avenue Melinde 31. Date filed (Month, Day, Year) NOV 1 U 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature Parka

in

and manner stated

			1 - For State Registrar	State of	f Maryland / De <i>C</i>	partment of ertificate of		, ,	ene . No. 2009	35946		
,	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Roslyn A. Facility Name (If not institution,	Т.		rtini 4b. City, Town,	or Location of De	2. Date of Death Month	Dav Year	3. Time of Death		
	Funeral			6. Sex 1 □ M 2 X F	7. Age (In yrs. last birthde	Randa11 If Under 1 Year Months Days	If Under 24 F	8. Date of Birth (Month, Day, Y) 12–12–19	Baltimore 9. Birth	place (State or Foreign		
	Director 3a-f show	ctor	214-24-3881 Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	81 Yrs. 10c. City, Town or Reisters			12-12-19		1and 10d. Inside City Limits 1 □ Yes 2 □ No		
	h with th	al Director	10e. Street and Number 6508 Deer Park	Road		10f. Zip Code	136		Citizen of What Cour	•		
15-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Medical Evening must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced 15. Decedent's (Specify only highest	Armed For 1 Yes If Yes, Giv Year or Date Education grade completed)	ZONo ye ates: 16a. De	3. Was Decedent of If Yes, specify Cub 1 □ Yes ※XXNo cedent's Usual Occurve kind of work done 1. DO NOT use retire	Specify: spation during most of y	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc. White		
Jana 212	be filed within tal Hygiene.	Be Com	Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, L.	College (1	-4or 5+)	ice Manage	er	Allame (First, Middle, Ma	BCO ICS Ins	surance		
aryla	should b and Ment marked martic e	오	Louis Palmier 19a. Informant's Name/Relationshi		19b. Ma	iling Address (Stree	Joseph	ine Palm:		Code)		
annore, M	ages 1 and 2 ent of Health s it: If Item 27 is y or other tra	1	Anthony J. Alber 20a. Method of Disposition 1 \overline{\text{M}} \text{ Burial } 2 \overline{\text{ Cremation } 3} 4 \overline{\text{Donation}} \text{ 5 \overline{\text{Other } (Spectrum)}}	3 □ Removal from S	State 20b. Place of Discemetery, co		k Rd. Re	isterstown Date 20	MD 21136	5 own, State		
Dalli	permit. F Departm Importar any injur		21. Signature of Funeral Service Li	censee . C	Jenkins 1	22. Name and Addre	ess of Facility ERAL HOM	E 11824 Re Reisters	ikesville, eisterstown stown, MD			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	aused the death. Do not each line. On ConCorrection or as a consequence of):		ing, such as card	liac or respiratory arrest	,	Approximate Interval Between Onset and Death		
,00,0	icate be executed physician and the burial-transit	dical Examiner										
.O. DOY 0	ath certif	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	ant at time of death	B ☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of delive Month	ery Day Year		
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	dring Prnysician: The h. After this certificate h. funeral director, page	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date o	npatient 2 ER/Outpati	of 28c. Inju	ner: 4 ☐ Nursing	Home 5 Residence 28d. Describe how		WS INSPICE		
	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	1 Matural 5 ☐ Pending investiga 3 ☐ Suicide 6 ☐ Could no determin	tion	of Injury - At home, farm, song, etc. (Specify)	M 1 □	rk?]Yes 2□No	28f. Location (Stree City or Town, S	et and Number or Rure State)	al Route Number,		
1	e nospire 24 hour ie Funera	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the xaminer: On the ba and mann	best of my knowledge, deasis of examination and/or er stated.	ath occurred at the ti investigation, in my	ime, date and pla opinion, death oc	ace, and due to the cause courred at the time, date	se(s) and manner as s and place, and due to	stated. the cause(s)		
	within vithin comp	Me	29b. Signature and title of certifier	h & B	urton	29c. Licens			Date signed (Month,			
			Deborah I	- Bixton	of death (Item 23a) (Type 0 5401 0	e, Print) OCOVICT	ROAD	No Randalis	town MD			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Re	egistrar's Sigrature	ple!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 Year Joseph M. Arduin 1:20 P. M November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign (Month, Day, Year) 1 🔀 M 2 🗆 F Months Days Hours Min. Maryland Director 220-18-4859 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland N/A Baltimore 1X Yes 2 ☐ No ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 214 W. Lorraine Avenue 21211 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? or . Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced Specify. Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me US Government Elementary/Seconday (0-12) College (1-4 or 5+) Boiler Mechanic Edgewood Arsenal Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Arduin Mary Elmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 W. Lorraine Avenue, Baltimore, MD 21211 Caroline Arduin Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 550ther (Specify) Entombren Gardens of Faith 11/12/2009 Fullerton, Maryland 21. Signature Funeral Service License 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Due to (or as a consequitive of): 1000005 disease or condition resulting in death) Doute Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year Yes 2 No 9 Unknown g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 NOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) roserrol

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 0 2009

32. Registrar's Signature

NSCMEU

09-08	462	
Carla	Austin	

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 1, 2009 0703 hrs Medical Examiner Karla Elizabeth Austin 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Johns Hopkins Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Months Days Hours Director 2 X F М Usual Residence of Decedent 0d. Inside City Limits È 10a. State l0b. County 10c. City. Town or Location Yes 2 No 28a-f show Director 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black. 11. Marital Status 12. Was Decedent Ever White, etc. Armed Forces? Never Married 2 X Married Yes f Yes, Give Year Yes 2 No specify: 3 Widowed Divorced "natural" ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n
injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19b. Mailing Address mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Cremation Removal from State Burial 12009 Other Specify Donation 5 21. Signatur of Funeral Service Licensee On Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Ruptured Berry Aneurysm Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ared for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and /sician/Medical 23a,PII,27,perm,E g898 12/9/09 TT #1, per ME g897 11/10/09 TT X UNPENDED X AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown 9 Unknown Phy as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use; Cardiomegaly with left ventricular Completed 24a. Was an 24b. Were autopsy findings available Hypertrophy prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 V Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: DOA Nursing Home 5 Residence 6 Other: 2 FR/Outpatient Inpatient 1 Yes ဥ 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 2, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35949 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Deathy Physician Month Day /Medical Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lagf birthday If Under 24 Hrs. 8. Date of Birth (Month, Day ecurity Number **Funeral** 1 M 2 Months Days Hours Min. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10d. Inside City Limits 28a-f show 10c. City-Town or Location traumatic event, the Medical Examiner mest be notified at Director Nes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: Specify 1 ☐ Yes 2 ☐ No 2 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental မ 19a. Informant's Name/Relation hip (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 27 Important: If item 2 any injury or other once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of 1 ☐ Burial 2 ☐ Cremation altimore. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breas -astatic Physician Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛒 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 □Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 14383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

State Registrar Harold

31. Date filed (Month, Day,

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Standi Fo.

32. Registrar's Signature

Joseph Richey Hospice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHIRLEY Wovember 6 **Physician** BERNICE BAKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS BALTIMORE HOSPICE RANDAIIS HOLUN
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) 213-54-2760 Months Days Hours Director 04/08/1950 MARVIAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show s 23a or 28a-f short Director 1 □Yes 2 No MD. BALTIMORE GWINN 10g. Citizen of What Country? 10e. Street and Number 4003 U.S.A. 21207 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Widdol Exature once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2.0 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married 1 ☐ Yes 2 No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COURT COURT CIERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21318 735 EAST 21ST. STREET BALTIMORE, MARY AND Keith JOHNSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2009 LANSdOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Facility THE DERRICK C. JONES FIH, P.A. 21. Signature of Funeral Service Licensee 4611 PARK HGTS. AVE, BALTIMORE, MARYLAND ZIZIS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any scaling to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed nemipkeji 224a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 DOther Specify S 110 SD (1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 A Natural Injury 1 □Yes 2 □No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division of Vital Records, certificate this After thi funeral of To the Hospital or Attending death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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3altimore, Maryland 21215-0036

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Burton

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5401, OLD COURT ROAD Randallstown MP

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ZOWN AUDE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE +105PITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Day | Hours | Min. | 4-8-1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Yrs Tenn Director 411-44-9500 79 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evanther must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Baltimore MΠ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SA 1017 Bonaparte Avenue 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Black <u>ک</u> Specify: 3☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Brick Layer 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Burton Stephen Brown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21239 Ardella Miles-daughter 1210 Ramblewood Road 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mills, MD Garrison Forest 11-13-09 Owings 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Balto, MD 21202 1101 E. north Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 **Physician** 125 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE ned by the attendir detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> page 2 should be 90 W(LSUTTE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2. No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ← Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

(Check only

29b. Signature and title of certifier

JOSH711

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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RACTIONE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35952 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 24, 2009 7:09 A M Roger Lee Buckingham Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Min. Month, Day Year 1944 Hours 218-42-3570 **1**XIX M 2 □ F 64 West Virginia Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes XX No Edgewood MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 US 1922 Chipper Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Specify: White Completed 3 Widowed XX Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Handyman Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evo 2 Mable Marie Likens James Wm. Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa, MD 21085 610 Harborside Drive Janet S. Walker (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highview Mem. Grdns 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/26/09 Fallston, Maryland 4 Donation 5 Other (Specify) Schimunek Funeral Home of BelAir 22. Name and Address of Facility re of Fune at Cervice Lic MOILZZ 610 West McPhail Rd., Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2: performe 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specific ု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider 5 Pending 2 🗌 No 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 5 State U Registrar

Please Type or Print in Black Indelible Ink 15759, 4166pies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5,2009 Month Bryna L. Burner November 10:40P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakcrest Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Director 223-46-3971 71 March 9,1938 Texas Usual Residence of Decedent 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wedical Examinar must to molified at Director VA. Falls Church 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 122 W. Westmoreland Rd. 22046 uSA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: þ 1 □Yes 2X No Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pre-School Teacher Education Itimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental ည Curtis Hickerson Golda McGilvray 19a. Informant's Name/Relationship (Type. Print) 199 70 and Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. Carla Simon DTR. 7 Perry Farms Dr. Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 12-10-2009 Virginia 22. Name and Address of Facility Sightimunek Funeral Home 236 Nottingham, Md. 21236 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cholomate carcinome
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and buriat-Due to (or as a consequence of) Box 68760, physician s the burial certificate be Physician/Medical ding p for use IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page autopsy this certificate perform Yes 2 Vital 1 □Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 000 Other: 4 Uursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes ٩ of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 27. Manner of Death 1 Natural Medical Certification: 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation after death.

I Director: Af d in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a Funeral L 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2. the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01

Registrar

31. Date filed (Month, Day, Year)

10

09-08463 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Robert Boothe 2009 35954 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day November 1, 2009 0638 hrs Medical Examiner Robert Boothe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6 Sex **Funeral** Days Hours Director 03-22-1927 223-30-0368 1 X M 2 Country) Usual Residence of Decedent 10c. City, Town or Location 3ny 10a. State or 28a-f show Harford Aberdeen MD must be notified at once. death with the Maryland Director 109. Citizen of What Country? 10f. Zip Code 10e. Street and Number 210 Golf Drive 21001 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", o injury or other fraumatic event, the Medical Examiner. If Yes, Give Yea 3 X Widowed Yes 2X No specify: Specify: White 4 Divorced ģ Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Factory Worker Shoe Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Blair Boothe Virginia Belcher ٥ 19a. Informant's Name/Relationship (Type, Print) 210 Golf Drive Aberdeen, MD 21001 Rita Boothe (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Highview Mem. Gardens 11-05-2009 Fallston, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ~xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown by the a' 9 Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be ۾ 24a. Was an autopsy has 2 st death? performed? 1 ✔ Yes 2 No 1 V Yes

9. Birthplace (State or VΑ 10d. Inside City Limits 1 Yes 2 X No 14. Race - American Indian, Black, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 22. Name and Address of Facility Schimunek Funeral Home of BelAir Approximate Interval Between Onset and Death The law requires that the death certificate be executed Year 23e. Did tobacco use contribute to the cause of death? Records, P. Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of certificate l ector, page No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? Inpatient 2 SER/Outpatient 3 DOA his 1 ✓ Yes 2 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of tniury Certification: 1 V Natural Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the f Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 2, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Day, Year, Registrar's Signatu State 4-sera U Registra

09-08464

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Unk Unk NQ 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 1, 2009 0728 hrs **Medical Examiner BROWN** AT.MA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center ICU 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign SOUTH Months Days CAROLINA Director 578-28-560 86 MARCH 16 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show items 23a or 28a-f shoust be notified at once. Itimore, MD 21215-0036

iii. Pages I and 2 should be filed within 72 hours after death with the Maryland armnent of Health and Mental Hygiene. PRINCE GEORGE'S SEAT PLEASANT MD Director 10g. Citizen of What Country? 10e. Street and Number 20743 USA 6312 MOROCCO STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status event, the Medic I Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 X Yes tant: If item 27 is marked other than "natural", or Specify: 3 X Widowed Divorced If Yes, Give Year Yes 2 X No specify: BLACK Ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT DOMESTIC 10th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALLACE MITCHELL SR. IDA COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11501 DUNDEE DRIVE MITCHELLVILLE, MARYLAND 20721 SONJA A. BROWN/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 2 X Cremation Removal from State Burial 11/10/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY Other Specify Donation 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Mulitiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Sa ned by the attending physician a detached for use as the burial -UNPENDED AMENDED Physician/Medi Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. signed | þ Yes 2 ✔ No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate has performed? No Yes 2 1 Yes 26 Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Division of Vital funeral director Be Other₄ examiner? Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 Residence 6 ER/Outpatient 3 this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: Pedestrian struck by auto Oct 31, 2009 1 1222 hrs Natural Yes 2 V No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi r death. Pending the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State)
Carrington Avenue @ Booker Drive, Seat Pleasant, Md. Suicide (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie November 1, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene 2009 35956 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anne E. Buaas November 2009 ÖĞ, 4:55 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Ba Limore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X 215-03-0035 90 Yrs Months Days Hours March 12, Country) Ma<u>ryland</u> Director 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If litem 27 is marked other than "nature" ----any injury or other transfer. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford Forest Hill MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 Bear Hollow Court 21050 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian δ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) At Home College (1-4 or 5+) Homeneker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Roszka Anna Pojefska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1219 Bear Hollow Court, Forest Hill, MD 21050 Alison Williams/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Recesser
Centery Baltimore, MD 11/10/09 4 Donation 5 Other (Specify) Sign to re of Funeral Service Licensee 22. Name and Address of Facility Exams Funeral Chapel & Cremation Services 8800 Halford Road Parkville, MD 21234 rd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Ir ediate Cause (Final disase or condition Physician/ Onset and Death EMPHUSEMA 1EARS Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year this certificate has been signed by the an director, page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 STROKE 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 United Nursing Home 5 Residence 6 Dother (Specify) HOSTICE 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural work? 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 3 | Suiciae 4 | Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOVEMBER 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTIMORE, MA 21204 DANIEUR DOBERMAN, MD 6701 CHAPLES ST, SUITE 4105 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MIN IN THAS Registrar

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2009 7:15 PM **Physician** November GRACE ALMOND BAKER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City Roland Park Place Healthcare Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Jan 2, 1914 Maryland Director 217-24-9899 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show giene. ir than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 □ No Directo N/ABaltimore City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 830 West 40th Street Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City of Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Important: If Item 27 Is marked other thin any Injury or other them. <u>Annapolis</u> <u>Social Worker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Saunders Mann Almond Lulu Blanche Hills 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10342 Sixpence Circle, Columbia, Maryland 21044
se of Disposition (Name of Date 20c. Location - City or Town, State (Son) Russell T. Baker, Jr. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 11/21/2009 | Pikesville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signaffe of Fineral actor Lipensee Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) advanced afterescleration cardievascular disease ears **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (5r as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 Thursple syrabes 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should ¹ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 | Matural 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier greger 73 Nevember 7, 2009 013657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TIS ABELLE THERREGOR, \$30 W. 40 H Streets Backmare, 7d 21211 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

09-08621 Henry Bullock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 35958

		1- For State Registrar			Cert	ificate of	Death				R	eg. No.			
Physici		1. Decedent's Name (First, Mic	dle,Last)							2	Date of Dea Month		Year	:	3. Time of Death
Medical Exami	ner	Henry George B	ıllocl	K							Novembe		9		0834 hrs
1		4a. Facility Name (if not institut	ion, give	street and number	er)	4	4b. City, Town, or Location of Death			f Death			ounty of D		
1		Holy Cross Hospital					Silver	pring					ntgome		
Funeral		5. Social Security Number	6. Sex	7. /	Age (In yrs. las	st birthday)	If Under		If Under				th(MM/DD/YYYY) 9. Birthplace (S Foreign		
Director		213-78-6404	1 X	M 2 F	53	Yrs	Months	Days	Hours	Min.	May 12	, 1956		Cour	ntry) Maryland
		Usual Residence of Decedent													
any		10a. State 10b. Count	У		10c. City, T	Town or Locati	wn or Location						_	ì	10d. Inside City Limits
nd Show	F	Maryland Anne	Arun	del			Lau	ırel							1 Yes 2 X No
aryla aryla at or	닳	10e. Street and Number					10f. Zip C	ode				l0g. Citize	n of What	Count	ry?
he M	Director	325 Old Line Av	enue				207	724					USA	1	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status		12. Was Decede	nt Ever in U.S	. 13. Wa	s Decedent	of Hisp	anic Orig	in? (Spe	cify Yes or No	D- 14	1. Race - A	meric	an Indian, Black,
eath item	ıne	1 X Never Married 2	Married	Armed Force		If Y	es, specify	Cuban,	Mexican,	Puerto R	tican, etc.)		White, e		
fler d		3 Widowed 4 D	ivorced	1 Yes If Yes, Give Year	2 X No	1	Yes 2	No	specify:			S	pecify:	Whi	ce
urs a tural	d by	15. Decedent's Education (Sp		or Dates:	ompleted)	16a. Deceden						16b. Kin	d of Busin	ess/In	dustry
i 72 ho 1 "na al Ex	Completed	Elementary/Secondary (0-12	2)	College (1-4 o	or 5+)	during m	ost of worki	ng life. I	DO NOT	use retire	ed)				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	du	N/A				N	/A						N/A		
5-0 ed wi lygie other	õ	17. Father's Name (First, Midd	e, Last)					1	8.Mother	s Name (I	First, Middle,	Maiden Su	ırname)		
214 be fill ntal F rked ent,	Be	Gilbert Donald	Bullo	ck					Anto	nia B	arata				
21 ould ould is man	၉	19a. Informant's Name/Relationship (Type, Print) Antonia Bullock – Mother 19b. Mailing Address (Street and Number or Ru 325 Old Line Avenue, Laure										State,	Zip Code)		
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiest and antier 17 is marked other than "natural", or other traumatic event, the Medical Examiner.		Antonia Bullock	- Mo	ther		325 0	ld Line	e Ave	enue,	Laure	1, Mary				
G, l and l and l Heal		20a. Method of Disposition		75 16		lace of Dispos rematory or oth		of cem	netery,		Date	20c. Lo	cation - Ci	ity or T	own, State
mol agges ent of nt: 1		1 Burial 2 X Cremati 4 Donation 5 Other		_ Removal from		lantic C		y, I	Inc.	11/1	0/2009	G1	en Bur	nie	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in the Maryland Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Ameral Service		ee			lame and A				7601	Sandy	Sprin	no R	nad
ini mg Per B		Mak	Mol	234		F1	eck Fu	nera1	L Home	, Inc	Laur	el, Ma	ryland		0707
Physician		23a. Part I. Enter the disease,	or compli-	cations that caus	ed the death. I	Do not enter th	ne mode of	dying, s	such as ca	ardiac or i	respiratory ar	rest, shock	c, or heart		Approximate Interval
/Medical		failure. List only one caus		Cardiac	arryth	nmia as	socia	ted	wit1	h acı	ute				Between Onset and Death
xaminer		Immediate Cause (Final diseas or condition resulting in death)	D D	ue to (or as a co	nsequence of)	epidio	vmiti	s a	nd o	rchi	tis				
		or condition resulting in death) Due to (or as a consequence of): epididymitis and orchitis Sequentially list conditions, b.													
	Je.	if any, leading to immediate cause. Enter Underlying Cause		ue to (or as a co	nsequence of)	:									
	Examiner	(Disease or injury that initiated events resulting in death) Las	C. =	ue to (or as a co	nsequence of)	:								-	
uted id ansit		events resulting in death) Las	d.		, ,										
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8760, tificate being physicias the buriant such such such such such such such such	Jed	IF FEMALE:		23c. If yes, out		,27,pe	rme,	goya	5 12/	21/0	9 11	23d.	Date of de	livery	
187 rtifica ing p		23b. Was decedent pregnant in past 12 months?	the	1 Live birth		2 Fe	tal death	3	Ectopic	pregnan	су		Month	D	ay Year
X 6 th cert trendiin truse a	hysicia		=1.= ==	4 Pregnant	at time of dea	4h	her (Speci								
Box 687 he death certifing the attending hed for use as t	hys	1 Yes 2 No 9 L		9 Unknown											
P.O. ss that the gned by it	by P	Part II. Other significant cond			ath but not res	sulting in the u	inderlying o	ause gi	iven in Pa	ırt 1.				-	he cause of death?
ords, P.C w requires that as been signed be		Parkinson's	dis	ease	- · · · · · · · ·						1	-			ably 4 🗹 Unknown
ord:	et	Autism									24a. Was				opsy findings available ompletion of cause of
tal Recorician: The law 1	Completed										perf 1 ✓ Yes	ormed?		ath?	2 No
n: The Triffica or, pa		25. Was case referred to medical 26.Place of Death (Check only of the control of											_		
Vital Rec ysician: The I his certificate director, page	Be c	examiner? Hospital: Institut 3 FR/Outpetient 3 DOA Other; Nursing He								Home 5	Resident	ce 6	Other:		
Division of Vital Records, rate dearn as a start death. The Inverse of Market of the Inverse of	-: To	Tes z ino								28d. Describe	how injur	y occurred			
on unding	ë	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No													
ivisior or Attend after death Director:	ica		estigation	28e Place of	Injury - At hor	me, farm, stre	et, factory,	office bu	uilding, et	c. 2	28f. Location	(Street and	d Number	or Rur	al Route Number, City
Div rs aft red ir	ertification:		uld not b termined								or Town,	State)			
Hospi 4 hou Funer ely fil	0	og - O-Hibra	Physicia	n: To the best of	my knowleda	e, death occui	red at the t	ime, dat	te and pla	ace, and c	fue to the cau	ise(s) and	manner a	s state	d.
Division of Vital Records, P.O. Box 68760, within 24 hours after the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical E	aminer:	On the basis of e	xamination an	d/or investiga	tion, in my	pinion,	death oc	curred at	the time, date	e and place	e, and due	to the	cause(s)
To To	Me	29b. Signature and title of cert		and manner state	su.		29c.	License	number			29d. Da	ate signed	(Mon	th, Day, Year)
		his his	(V					0.C.N	И.Ε.			Nove	mber 7,	, 200	9
		30. Name and address of pers	on who or	ompleted cause of	f death (Item :	23a)								-	
		•		edical Examir			et, Baltim	ore, N	MD 212	201					
S	tate	31. Date filed (Month, Day, Yea	r)	32 Regis	trar's Signaty										
Regis		MOV 10		Bus	w B	for	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 227 AM Sernar Dennis 2009 Noven se /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhmore University of Hors and Medical center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**M** 2□ F Days Months 230-68-8224 59 Director /01/1950 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Anne Arundel MD Pasadena 10g. Citizen of What Country? 10e. Street and Number 8392 Armstrong Drive 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩/95 2 □ No 1967 -If Yes, Give Year or Dates: 1970 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1□Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician U.S. Dept of Navy 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Louise Hummer ျ Irving J. Bernard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any Injury or other traur 8392 Armstrong Drive, Pasadena, MD 21122 Janine Bernard / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Bavview Crematory 11/12/09 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Formal Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, <u>169 Riviera Drive, Pasadena, MD 21122</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic lung concer /Medical Due to (or as a consequence of): Examiner asking Dronwy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sele consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident

Box 68760, P.0. Division of Vital Records,

filed within 72 hours after death with

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

3altimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Lemeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

within 24 hours at To the Funeral D completely State

29b. Signature and title of confifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 29c. License number 22180 November 8, 2009

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balhmore MD 2/201 22. South Green conda

Registrar

31. Date filed (Month, Day, Year) 0 2009

6 Could not be determined



adie Brown		1- For State	ate of Maryla	•	artment of		and N	Menta	ΙНу		2	n n •	Q Q	5960
Physici	ian/	1. Decedent's Name (First, Midd	le,Last)				_	-		Date of Deat	h		3. Time of	
ledical Exam	iner	Saute	Brown				_			Month November	Day Yes 4, 2009	ar	0630	hrs
-		4a. Facility Name (if not institution Bon Secours Hospita		imber)		tb. City, Town Baltimor		ation of E	Death		4c. County	of Death NA		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. to		If Under 1		f Under 2			h (MM/DD/YYY	T !-		
Director		249-08-4380	1 M 2 F	54	Yrs		Days	Hours	Min.	07-2	8 - 55	Co	untry) S	c
ıy.		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Locati	on							10d Ineid	e City Limits
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Aaryland 28a-f show	[향	10e. Street and Number	-	Da	TUTINOL	10f. Zip Coo	de			<u> </u>	ng. Citizen of W	hat Cour		
he Ma 1 or 28	Director	1720 W. Lal	Tavette	Δυρμίο			.217	ı			USA		,	
215-0036 be filed within 72 hours after death with the Maryland ratel Hygiers other than "natural", or items 23a or 28a-f Shi ent, the Medical Examiner must be notified at once		11. Marital Status	12. Was Dec	cedent Ever in U.		s Decedent o	of Hispan	ic Origin'	? (Spec	ify Yes or No-	14. Race	- Ameri	ican Indian	Black,
death or iter	Funeral	1 Never Married 2 N	1 Yes	2 X No	lf Y	es, specify Ci	uban, Me	exican, Pi	uerto Ri	can, etc.)	Whit		Amer	
s after ral", o	Į ģ	3 Widowed 4 Div	orced If Yes, Give Yes	ar		Yes 2X					Specify:		rica	n
hours 'natu		15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Deceden during m	t's Usual Occ ost of working					16b. Kind of Bu	ısiness/l	Industry	
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5-0036 ited within 72 he Hygiene. I other than "n: the Medical E)	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA Labo 17. Father's Name (First, Middle, Last)						oorer Janitor 18.Mother's Name (First, Middle, Maiden Surname)						ai c	0.
21215-003 uld be filed withi Mental Hygiene marked other ti	8	Celess		Carrie Bell Johnson										
221 hould od Me is ma	Celess Brown Carrie Bell J								ber, City or Town, State, Zip Code)					
Nore, MD 2'sges I and 2 should and Affelth and M I: If item 27 is ms other traumatic e		Deverick Howell - Son 1515 Ruthlan 20a. Method of Disposition 20b. Place of Disposition (Name of cemete						d A		ue Ba	ltimor	e,	MD 2	1213
ages 1 a nt of He fit I fite		1 Netrod of Disposition 1 Netrod of Disposition Cremation	n 3 Removal fi	om State	crematory or oth	ner place)	or cemete			0-09		-		
Baltimore, Dermit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other S		I ^M							Lansd			
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Services	Licensee			ame and Add		-	Wy	lie F	uneral Baltim	Но	me P	.A. 2121/
Physician	-	23a. Part I. Enter the disease,		aused the dawn									-	mate Interval
'Medical	9 1	failure. List only one cause Immediate Cause (Final disease		drug (c	ocaine,	metha	done	۵, و	mor	phine)	and			n Onset and Death
		or condition resulting in death)	Due to (or as a	consequence o	_{of):} alcono	1 into	XICE	ition	1					
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	of):									
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60, ate be	Med	IF FEMALE:	23c. If yes,	23a,27,	∠8a−r,p mancy	ermE,	goyo) 12/	29/	09 11	23d. Date of	delivery	<u> </u>	
OX 68760 eath certificate be attending physicare for use as the bu	Physician/Me	23b. Was decedent pregnant in t past 12 months?				tal death	3 E	Ectopic pr	regnand	у	Month		Day	Year
Box e death o the atten ed for us	sic	1 Yes 2 ✔ No 9 Un	known 9 Unkn	nant at time of de own	5 Otl	ner (Specify)								
O. B. at the de by the ached f		Part II. Other significant condi			esulting in the u	nderlying cau	use giver	n in Part I		23e. Did to	bacco use contr	ibute to	the cause	of death?
ires that the signed by I be detached	d b									1 Yes	2 No 3	Prot	oably 4	Unknown
ords, w requir s been s should t	ete									24a. Was a				ngs available of cause of
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of Vital Records, bg Physician: The law require the this certificate has been si neral director, page 2 should b		25. Was case referred to medica			_	26.F	Place of I	Death (Ch	neck on			V 10		
Vital tysician: this certif	o.	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Oth	er ₄ N	lursing l	lome 5	Residence 6	Other	r.	***
n of ling Ph After t funeral	<u>;</u>	27 Manner of Death 29a Date of Injury 29b Time of Injury 28c Injury of Work? 29d Describe how injury approach												
SiOn trend death. ctor: y the f	atic	Natural 5 Pending Investigation Fd 11/4/09 Fd 0530 hr s 1 Yes 2 No unk Red 11/4/09 Fd 0530 hr s 1 Yes 2 No unk 2 Accident Street and Number or Rule 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rule 28f. Location (
Division tal or Attendians after death.	Certification:	3 Suicide 6 X Cou	ia not be i			et, factory, off	ice build	ing, etc.	20	or Town, S	street and Numb tate) 1720	erorRu W • I	ral Route N Lafay	Number, City ette Ave
<u>1</u> 3 5 5 €	Ç	4 Homicide	1	reside		. 1 . 4								-
To the Hos within 24 h To the Fun completely	<u>[2</u>	(Check only	hysician: To the be miner:On the basis											
To the within 2 To the complet	Medical	29b. Signature and title of certification	and manner	stated.			cense nu				29d. Date sign			ear)
		alle	1	100			.C.M.E				November			
		30. Name and address of person	who completed cau	se of death (Item	n 23a)									
AV		Russell Alexander MI		Medical Exam		Penn Stre	eet, Ba	altimore	, MD	21201				
	tate		32. R	strar's Signatu	ure	*								
Regis	Stran	NOV I	2009	Desert.	7 4	2 46 1								

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . Month 10:55 PM Zane Grey Beard venibe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🏝 M 2 🗆 F Hours Georgia Director 238-52-0366 73 Usual Residence of Decedent or 28a-f show notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Completed by Funeral 413 Fawcett Street 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene.
If item 27 is marked other than "nature or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roscoe Beard, Jr. Mary Cheek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine E. Dickens/Sister 1802 Queen Anne Square, Bel Air, MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Ardent Cremation Services : 11/09/2009 4 Donation 5 Other (Specify) Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 M0119 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ sophanea disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Microun alle there Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine UnKrown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 243894612

State Registrar arkwais

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ezinma

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Bat

		_	For State Registrar		ıryland		rtment of l	Health and M Death	lental Hy	giene Reg. N.20	09	359	362
	Physicia		1. Decedent's Name (First, Middle, La	,			_		Date of Dea Month		Year	3. Time o	
	/Medic	al	Violet	Agnes		Bir			Novembe	1		12:3	38P M
	Examin	er	4a. Facility Name (If not institution, giv					r Location of Death			ty of Death	1 1	
W.C.			Tate Hospice Ho 5. Social Security Number 6. S		(In ure la	st birthday)	Linthio		8 Date of Bird		Arun		or Foreign
	Funeral Director			□M 2X F	94		Months Days	Hours Min.	8. Date of Bird (Month, Da Nov • 28	y, _{Year)} 3, 1914	Coul	place (State ntry) MD	
Maryland	f show	tor	10a. State 10b. County MD Arne Ar	ınde1	10c. City, Seve	Town or Lo	cation				1	10d. Inside C	lty Limits
- P	r 28a	irec	10e. Street and Number		DCVC		10f. Zip Code			10g. Citizen o	What Cour	ntry?	
tiw d	23a c	a l	1893 Estate Cou	rt			21144			U.S	.A.		
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantice must be notified at other.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 22 N If Yes, Give Year or Dates:			Vas Decedent of F Yes, specify Cub □Yes 2 XNo	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bl Spec	ace - Americack, White,		
-0-S	atura cel E	ted	15. Decedent's Er	lucation	I	16a. Deced	lent's Usual Occup	pation	I	16b. Kind of	Business/In	dustry	
Baltimore, Maryland 21215-0036	giene. ir than "n ine Medi	Completed	(Specify only highest gra	College (1-4or 5+	+)	`life. L	kind of work done DO NOT use retire Iresser	during most of worki d)	ing	Cosme	tolog	У	
nd	al Hy d othe vent,	Be C	17. Father's Name (First, Middle, Last,					18. Mother's Name	e (First, Middle,	Maiden Surna	ime)	_	
yla ylab	Ment arkec atic e	2	Samuel Lewis Pe					Caroline	Agnes	VonDre	hle		
Aar.	is m		19a. Informant's Name/Relationship (Type. Print) Grand Daugh	d hter			and Number or Rura		•			
e , n	Health		Mrs Rebecca A. S.	ingleton /				Court Seve		cyland 20c. Location	2114		
imor	D partment of I Important: If ite amy Injury or o'		1 Ø Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Gle	n Have		Park 11, 2	2009	Glen B	urnie	, MD	
3alt	Important Injury		21. Signature of Funeral Service Licer	isee	/a.	22	. Name and Addre	ess of Facility Sir PA 1 2nd A	ngleton	Funera	1 Cre	mation	1 0 6 1
1.1	nysician Medical xaminer		23a. Part1. Enter the dise e, or come shock, or he that e. List only Immediate Cause (Finel disease or condition resulting in death)	plications that caused one cause on each line a. Due to (or as a	the death.	Do not ente		ng, such as cardiac				Approxima Interval Be Onset and	ite itween
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.									
O. Box 6	y the attending phys ched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of Live birth 24 Pregnant at 9 Unknown	2 🗀 Fetal o	death 3	Ectopic pregnand Other (specify)	су			eate of deliv	,	Year
rds, P.	n signed by the a uld be detached f	2	Part II. Other significant conditions of	ontributing to death bu	t not result	ting in the ur	derlying cause giv	ven in Part I.		obacco use co ⁄es 2□ No		he cause of	
Division of Vital Records,	cate has been si page 2 should I	Completed							24a. Was autor perfo		prior to co	opsy findings ompletion of	available cause of
ia ia	certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of Death			1 🗆 163	2 LINO	
of V	this ce al direc		1 Yes 2 Mo	Hospital: 1 ☐ Inpatier	nt 2 🗆 E	R/Outpatien	t 3□DOA Oth	ner: 4 🗆 Nursing Ho	me 5 ☐ Resid	dence 620	ther (Speci	POKNICI	Han
Sion C	eath. :or: After th the funeral	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b		(Year)	28b. Time of Injury	M 1	k?]Yes 2 □ No	28d. Describe I				
Division Att	within 24 hours after death To the Funeral Director: completely filled in by the i	Certifi	4 Homicide determined	building, etc.					28f. Location (8 City or Tov	vn, State)			nber,
the Hospital	in 24 hor he Fune pletely fi	Medical		ysician: To the best o niner: On the basis of and manner stat	examinati								s)
7 10	with To t	Σ	29b. Signature and little of certifier				29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)	
				S	10		> 17	51551		Works	100	7,20	109
			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, I	Print)	n	6/1	?1	1.	line	1

State Registrar

09-08601						
Linda	Bradley					

Linda Bradley		Department of Health and Mental H	ygiene				
	1- For State Registrar	Certificate of Death	Reg. No. 2019 3596				
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Bradley	2. Date of Death Month Day Year November 5, 2009 3. Time of Death 1046 hrs				
1-	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death					
	4101 Groveland Avenue Apt. 1-A	Baltimore					
Funeral Director		In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Foreign				
Director	220-38-90H 10M 2VF	(p 6 Yrs.	11 29 1942 Country) MD				
amy	Usual Residence of Decedent 10a. State 10b. County 110	Dc. City, Town or Location	10d. Inside City Limits				
show of the or	MD NIA	Baltimore	1 1 1 No				
Maryla Maryla 28a-f	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
with the Maryland ns 23a or 28a-f sho	4101 Groveland Av	e. 13/flc. 21215	USA				
r death with the Maryland or tiems 23a or 23a-f sh	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto					
fter de	3 Widowed 4 Divorced If Yes, Give Year	No 1 Yes 2 No specify:	Specify: Black				
nours aft	15. Decedent's Education (Specify only highest grade compl	eted) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret					
36 in 72 l han "1 lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	Don't al Educati				
5-0036 led within 72 hour. Hygiene. other than "naturthe Medical Exan Completed	17. Father's Name (First, Middle, Last)	lacher's Nam	e (First, Middle, Maiden Surfame)				
21215 21215 Juld be file Junarked of the cerent, the	Herbert Keys	Glad	lus Armstead				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rufal Route Number, City or Town, State, Zip Code) 207				
and 2 sho ealth and tem 27 is	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery.	Date 20c. Location - City or Town, State				
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other trin	1 Burial 2 Cremation 3 Removal from State		16/09 Batto. MO				
Baltin permit. P. Departmet Importan injury or	4 Donation 5 Other Specify: 21. Signature 1 The Specific	22 Name and Address of Facility	38 Funeral Homo, P.A.				
	Coursey Lay	1222 W. Nos	th Ave Balto MD 21216				
Physician /Medical	23a. Pa . Ent. the dise \(\mathcal{H} \), or complications that caused th failure. List only one ause on each line.	e death. Do not enter the mode of dying, such as cardiac	Between Onset and				
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Atheroscles Due to (or as a consequence)	rotic cardiovascular disea	S e Death				
	Sequentially list conditions, b.	derice or).					
iner	if any, leading to immediate Due to (or as a consequence. Enter Underlying Cause	uence of):					
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence)	uence of):					
0, E be executed e be executed burial - transit edical Ex	d.						
	X UNPENDED AMENDED 23a, I	PII,27,perMe, G897 11/24/0	9 TT 23d. Date of delivery				
certificat nding ph use as the	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn					
Box 68760, re death certificate be the attending physic for use as the burn hysician/Mec	1 Yes 2 No 9 Linkneys	me of death 5 Other (Specify)					
	The MALLE 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contribute to the cau						
O to the state of							
of Vital Records, ing Physician: The law requires. After this certificate has been signeral director, page 2 should be in: To Be Completed			24a. Was an autopsy findings available prior to completion of cause of				
Reco	4		performed? death? 1 ✓ Yes 2 No				
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical examiner?	26.Place of Death (Check					
of Vi Physi er this eral dir	1 Yes 2 No Inospital 1 Inpatient		ng Home 5 Residence 6 ✔ Other: Scene				
on of ' anding Ph ath. r: After t he funeral	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Yea	1 Yes 2 No					
ivision lor Atten after death Director: I in by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injur	ry - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City				
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune Medical Certification:	4 Homicide determined (Specify)		or Town, State)				
	CONTROL ONLY	knowledge, death occurred at the time, date and place, an nation and/or investigation, in my opinion, death occurred					
To the Ha within 24 To the For completel	29b Signature and title of certifie	29c. License number	29d. Date signed (Month, Day, Year)				
	Still 5/1/10 ////	O.C.M.E.	November 6, 2009				
	30. Name and address of person who completed cause of dea	ath (Item 23a)	1				
Ψ	Victor Weedn MD JD Assistant Medical E		21201				
State Registrar	31. Date filed (Month, Day Year) 32. Registrar's	Signature					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35964 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10-26-2009 1105 A Melvin J. Carmine, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air | Tit Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01-20-1951 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 M M 2 □ F 58 Director 214-82-4259 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examinar must be notified at 10a, State 1 ☐ Yes 2 ☑ No Director Harford Abingdon MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 3418 Henry Harford Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, I'm Masone. Elementary/Secondary (0-12) College (1-4or 5+) Dependent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Bremer Melvin J. Carmine, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3418 Henry Harford Drive Abingdon, MD 21009 Shirley A. Carmine (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 10-31-2009 Timonium, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee M Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PSTS **Physician** /Medical Due to (or as a consequence of) Examiner PNEMMON Sequentially list conditions, Due to for as a consequence of Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ij 1 ∐ Yes 202X No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 10 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

Division of Vital Records, P.O. Box 68760 the Hospital or Attending within 2 To the I

death with the Maryland

8

31. Date filed (Month, Day, Year) State Registrar U 2009

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 MPPCR CHESAPEAKE DR. BE 32. Registrar's Signature

MD

and manner stated.

29c. License number

100063220

GEORGE MIR, MD

29d. Date signed (Month, Day, Year)

ISCKARMS

10/26/2009

		State of			alth and Mental Hvo	•		
State of Maryland / Department of Health and 1 - State Registrar State of Maryland / Department of Health and Certificate of Death						Reg. No 2009 35965		
Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month					
/Medi	cal	4a. Facility Name (If not institution, give street and num	nation of Doath	4c. County of Death				
Exami	ner	Oakcrest Care Center	iber)	4b. City, Town, or Lo Parkvi		Balto.		
Funeral	Г	1 1X 14 0 1 1	7. Age (In yrs. last birthday)		Hours Min. 8. Date of Birtl (Month, Day March	9. Birthplace (State or Foreign Country)		
Director		Usual Residence of Decedent	88 Yrs.		March 3	30,1921 Maryland		
ryland show	١.	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits		
he Ma 28a-f s	Director	Md. Balto.	Par	ckville		1 ☐ Yes 2 ☐ No		
sa or	i Di	10e. Street and Number 8820 Walther Blvd. Unit	2316	10f. Zip Code 2123		10g. Citizen of What Country? USA		
ems 2	Funeral				anic Origin? (Specify Ye's or No- Mexican, Puerto Rican, etc.)			
36 s after	by Fu	1 Never Married Married 1X Yes If Yes, Giv	2 □ No e		Specify:	Specify: White		
2 hour	ted k	15. Decedent's Education	on .	16b. Kind of Business/Industry				
1215 ithin 7 ne.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-	4or 5+) life.	e kind of work done during DO NOT use retired)	ng most of working			
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar mast be notified at		12th 17. Father's Name (First, Middle, Last)	Plar	nt Manager	3. Mother's Name (First, Middle,	Nail Company Maiden Surname)		
rlan	To Be)		Anna Riordan				
Maryland		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street and	Number or Rural Route Numbe	r, City or Town, State, Zip Code)		
e, h 1 and Health em 27	h	Corinne James 20a. Method of Disposition			m Drive New Ma	arket, Md. 21774 20c. Location - City or Town, State		
Pages nent of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cree Dulaney V	osition (Name of matory or other place) Valley	1	Cimonium, Md.		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at any oince.		21. Signature of Funeral Seasce Licensee		2. Name and Address of	of Facility Schimunek	Funeral Home		
M 205 20		Mer 25m		9705 Bela	ir Rd. Notting	gham, Md. 21236		
Dhysisian	,	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima Interval Be Onset and disease or condition resulting in death) Due to (or a sa consequence of):						
Physician /Medical	ı	disease or condition resulting in death) Due to (0						
Examiner	L.	Sequentially list conditions, b.	1,22					
uted Insit	Sequentially list conditions, that y, leading to man class to consequence of): Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
3760, step be executed system and he burial-transit								
8760, cate be exc physician a the burial-	dical	d						
of Vital Records, P.O. Box 6871 Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the the street of	Physician/Medi	IF FEMALE: 23c. If yes, outc	23c. If yes, outcome of pregnancy			22d Data of delivery		
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Division of Vital Records, to Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be d	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place 6 buildin	of Injury - At home, farm, sti g, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, in, State)		
spital								
Property and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and durant manner stated.								
7 Towiti	Σ	29b. Signature and title of certifier	radi/	29c. Licente nu	umber 2420)	29d. Date signed (Month, Day, Year)		
10		30. Name and address of person who completed cause	of death (Item V3a) (Type.	Print)	12	11/6/07		
10		have bunewith	n will	1 6038	walther B	(v) Parkallethal		
Sta Regist		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	Kol		1259		
		TIVE .						

State of Maryland / Department of Health and Mental Hygiene 35966 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 02 2009 JoAnn November 07:27 PM Kathleen Cox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8007 Alexis Court Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🖾 F 72 213-32-0590 Director Nov. 1936 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Exactiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 436 Granada Court 21108 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S Was Deceue..._ Armed Forces? 1 □Yes 2 ☑ No 14 Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White 1 ☐ Yes 2√2 No à Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Secretary 8 Real Estate and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winchester Arthur McNally Anne Marv ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 t Michael P.R. Cox Sr. (spouse) 436 Granada Court, Millersville, permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Nov. 06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2009 Baltimore, Maryland 21. Signal re of Fundal Service 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complica ons teat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 MOUTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed resulting in death) Last Due to (or as a consequence of): burial-t Box 68760, attending physician for use as the burial Physician/Medical The law requires that the death certificate IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 Tyes 20 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 20 No 1 □ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 125 Jakes V.S. 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 10 LMARL 31. Date filed (Month, Day, Year) State Registrar

09-08667 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Corbin 2009 35967 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 7, 2009 1904 hrs Medical Examiner Kenneth Corbin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NA **Baltimore** Maryland General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Foreign Min. Months Days Hours Director Country) 10-13-60 49 215-74-8081 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1X Yes 2 No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. MD NApermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 330 or 300. feature. Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1509 W. Lexington Street 21223 USA Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. African Armed Forces? 1 X Never Married 2 Married 2X X No Yes Yes 2XX No specify: Yes, Give Year Widowed Divorced American ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 11th Grade NA Laborer self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be James Corbin Mary Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code21223٩ 19a. Informant's Name/Relationship (Type, Print) 1509 W. Lexington Street Baltimore, MD Monica McCants-Sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) or other Burial 2 X Cremation 3 Removal from State Metro Crematory 11-10-09 Catonsville, Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home ∮38 N. Gilmor Street Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cocaine and narcotic intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit Physician/Medical XUNPENDED AMENDED 23a, 27, 28a-f, permE, g897 11/13/09 TT Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be a 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 Yes To the Hospital or Attending Physician: 'within 24 hours after death.'
To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: Other₄ Inpatient 2 PR/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 1 Yes 2 X No unk neral Director: / Pending 11/7/09 2 Accident Investigation 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1802 MCCulloh St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined sidewalk (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. November 8, 2009

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

31. Date filed (Month, Day, Year

OCME

FL.

Year

2 No

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 9 2. Date of Death
NMpoth 2, Day 0 0 9 Year Decedent's Name (First, Middle, Last)
Brenda Delois Cook Physician/ 47A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2233 E. Biddle Street Baltimore N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Feb. 24 Funeral 9. Birthplace (State or Foreign Days Hours Year 216-62-1188 Country) S.Carolina Yrs Director 54 1<u>95</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD N/ABaltimore XXYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2233 E. Biddle Street 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Public Schools years permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumers. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Allen William Cook Eartha Lee Pearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ben Cook/ Brother 3001 Pulaski Highway Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State King Memorial Park 11/7/09 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licens lles 5240 Reisterstown Rd Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death -Physician/ ACQUIRED IMMUNE DEACHENW STND rume disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CELL CARCINOM. SIGNET Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami -transit OBSTRUCTION SMAZI BONEZ and that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-t Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year to the Funeral Director; After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has I autopsy performed? NA 2 🗆 No 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying regard (Check only one 29b. Signatur and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Primary CARE D0056946 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

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32. Registrar's Signature

Dammay

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Ce	rtificate of L	Death	Reg	g. No 2009	35969
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		James Lincoln		Jr.			November	7 2009	5:38 P ^M
1	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Death	
			Carroll Hospital 5. Social Security Number 6. So		yrs. last birthday		stminster If Under 24 Hrs.		Carro	pplace (State or Foreign
h	Funeral Director		213-24-9929	X M 2□ F	79 Yrs.	Months Days	Hours Min.	Jan. 6,	Year) Cou	yland
	land		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits
	Mary F sh	후	Maryland Carro	11		Westmin	nster			1⊠Yes 2□No
	r 28a	Director	10e. Street and Number			10f. Zip Code	IDCCI	10	g. Citizen of What Cou	intry?
	th wit	al D	802 Uniontown Rd	.•			21158	3		U.S.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Michell Eraminat must be nutilised at once.	by	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 XNo If Yes, Give Year or Dates:			Specify:		Specify: Wh	ite
5-0	72 hc 'natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	i (Give	edent's Usual Occup e kind of work done o	during most of work		6b. Kind of Business/I	ndustry
12	vithin	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	,		ab document	J.,
0 0	filed v Hygie ther t	ပ္သ	17. Father's Name (First, Middle, Last)			carpente		e (First, Middle, Ma	shipyare	us
aŭ	d be ental	To Be	James L. Crab	hs. Sr.				rence Ha		
ar.y	shoul nd M marl	F	19a. Informant's Name/Relationship (·	19b. Mail	ing Address (Street			City or Town, State, Z	ip Code)
Š	alth a 27 Is 27 Is		Alice R. Crabbs/	wife	80	2 Unionto	wn Rd.	Westmins	ter, MD 21	158
J. C	es 1 a of He litem		20a. Method of Disposition	20	0b. Place of Disp	osition (Name of ematory or other place	e)	Date 2	0c. Location - City or 7	own, State
Ē	Page nent ant: M		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	Winters	Cemetery	11/1		r. New Wind	
Balt	permit. Departi Importi any Inj		21. Signal re if Funeral Service Licen	Se Xarlo		2. Name and Addres			uneral Homeor, MD 217	
	_		23a. Part 1. Enter the disease, or comp	olications that caused the						Approximate Interval Between
· Pariti	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. N	RSA	Prey	monia			Onset and Death 2 WCUCS
	/Medical Examiner		Tooding in dodain	Due to (or as a cor	nsequence of):	(0)	00			71.000
	100	ē	Sequentially list conditions,	b. Due to (or as a cor	isequençe of):		·/			24015
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			IF FEMALE:	00-16					1	
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o	the d	ysic	1 □Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	e or dealir 5	Other (specify)				
σ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	quires nn sig uld be	d by						1 ☐ Yes	s 2 No 3 Pr	obably 4 🗌 Unknown
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æ	The law ate has bage 2 s	E O					-	autopsy perform 1 🗆 Yes 2	ed? death? □No 1 □Yes	ompletion of cause of 2 ☑No
ita	slan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		
<u>~</u>	Physician: The la r this certificate ha ral director, page 2		1 Yes 2 No		2 ER/Outpatie		4 LI Nursing H	ome 5 Resider	nce 6 Other (Spec	cify)
Ē	6 6	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	ar) 28b. Time Injury	Worl		28d. Describe how	w injury occurred	
Sio	Attending Physician: r death. ector: After this certifice by the funeral director, p	cati	2 Accident investigation 3 Suicide 6 Could not be		At home form	100	Yes 2□No	20f Location (Ot-		or I Brook Alberta
\leq	or A after of Direction by	Certification: To	4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	pecify)	ireet, lactory, office		City or Town,	eet and Number or Ru State)	rai Houte Number,
	spital ours neral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my	v knowledge, dea	th occurred at the til	me, date and place	, and due to the ca	ause(s) and manner as	stated.
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical		niner: On the basis of exa and manner stated.		investigation, in my o	pinion, death occu	rred at the time, da		
	To th withir To th comp	Me	29b. Signature and title of certifier	11-00	Mn	29c. Licens	e number	29	Od. Date signed (Month	
			•	merco			0 5 409	15	NOV 9	2009
	١.		30. Name and address of person who		(Item 23a) (Type	, Print) A	e number 0 526 g 19mu	,	MD 2	152
النور	Q		BINO CHACK	32. Registrar's S	>78	ner III	time		. 7 6	()/
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrars s	orgriature					

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 2. Date of Death Decedent's Name (First, Middle, Last) Physician /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Director 231-44-1285 71 Jan. 24, 1938 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 😾 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a 641 Hornbeam Road 21040 Funeral USA Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. þ Specify 3 ☐ Widowed 4 ☐ Divorced 'natural", White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industr event, the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4 or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental If item 27 Is marked o မ Herman Gaines Woodward (unk) Gillenwater Ada 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Crenshaw / Spouse 641 Hornbeam Road, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gardens 11-10-09 Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician an as the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 autopsy 1 Yes 2 🗌 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home မ 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Pending 2 Accident investigation 1 Tes 2 🗌 No the 1 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of certifier 29c. License number

within 7 ٥

State Registrar

RUSSELL 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WESSON

M.O.

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of Heal tificate of Dea			ene eg. No. 200	9 35971
			Decedent's Name (First, Middle, La	ast)				2. Date of Death	1	3. Time of Death
	Physicia Medic		Robert	Edward	Cre	amer	N	Month November	Day Year 7, 2009	8:02 A ^M
	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or Loca	ation of Death		4c. County of Dea	
-	رم 		Gilchrist Hosp 5. Social Security Number 6.		- food bindonland	Towson If Under 1 Year If U	Inder 24 Hrs. 8		Baltimo	
ı	Funeral Director		216-34-7841	1 № M 2 □ F 72	s. last birthday) Yrs.	Months Days Hou		3. Date of Birth (Month, Day, 7/8/19	Year) 9. BI 37 Ma	irthplace (State or Foreign ountry) ryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation				10d. Inside City Limits
	laryla 3a-f s iffied	Director	MD	Ва	altimore					1 🔀 Yes 2 □ No
	or 28		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23a ust b	Funeral	600 S. Light St	reet Apt. #703	1	21202			U.S.A.	
	death item		11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. V	/as Decedent of Hispanio Yes, specify Cuban, Me	ic Origin? (Specif exican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
36	after al", or xami	d by	1 Never Married 2 Married Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates,		☐ Yes 2 🛣 No Spe			0	ite
9	hours natur iical E	Completed	15. Decedent's	Education	16a. Deced	ent's Usual Occupation			16b. Kind of Business	
218	in 72 le. han "l	d w o	(Specify only highest g Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	ind of work done during NOT use retired)	most of working			
21	d with lygien ther ti nt, the	ادما	10		S	alesman			Automoti	ve
and	oe file Intal H ced of	10 B	17. Father's Name (First, Middle, Last, Elmer	William	Crea		Mother's Name (I Josephin		aiden Surname)	Surdel
ary.	ould I		19a. Informant's Name/Relationship	Type, Print)		g Address (Street and No			City or Town State 7	
Š	d 2 shalth a		Elmer J. Creame	c/ Brother					•	e, MD 21234
ore,	of He of He fiterr		20a. Method of Disposition		. Place of Dispos		Dat		20c. Location - City o	
<u>E</u>	Page ment ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🕱 Donation 5 ☐ Other (Spec		natany Gi	Ets Registry	11/10,	/2009	Hanover, N	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Cen	nsee	7.	Name and Address of F	ey Dr.,	tomy Gi Ste. P	fts Regist , Hanover	try , MD 21076
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de	eath. Do not ente	r the mode of dying, suc	ch as cardiac or r	espiratory arres	it,	Approximate Interval Between
	nysician/		Immediate Cause (Final disease or condition		QSCU10	r accide	T			Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a conse						
		ier	Sequentially list conditions if any, leading to immediate	b. Due to (or as a conse	equence of:					
8.	ted J unsit	Examiner	cause, Enter Underlying Cause (Disease or linjury	240 10 (07 40 4 00)	5 4 05/105 51/1					
	execu an and fal-tra	Ex	that initiated events resulting in death) Last	C. Due to (or as a conse	equence of):					
160	cate be executed physician and the burial-transit	edical		d						
687	rtifica ing ph e as th		IF FEMALE:							_
Box 6	ath ce attend for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live Birth 2 For the second Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
œ.	v requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	ordeath 5	Other (specify)				
P.0	that t ned b e deta	oy P	Part II. Other significant conditions	contributing to death but not r	resulting in the ur	nderlying cause given in I	Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ds,	quires en sig ould b	ted	Chrounc gozzto	which some	nongo	115036		1 ☐ Ye	s 2 □ No 3/5√F	Probably 4 🗆 Unknown
COL	aw rec	Completed by	Coronary art	y discise	7			24a. Was an autopsy		utopsy findings available completion of cause of
Re	The cate h		7	7				perform 1 Yes 2	ed? death?	s 2 🗆 No
ital	sician certifi rector	8	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:		Othor	Death (Check or		25.4	1)
of V	Physer this eral di	e: <u>T</u> o	1 ∐ Yes 2 X No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatient 28b. Time of	28c. Injury at			nce 6 Other (Spectro)	city) HOSOICQ
ou c	nding ath. r; Afte ie fun	icat	1∕ Natural 5 ☐ Pending 2 ☐ Accident Investigation		injury	work? M 1 ☐ Yes	1	a. 50001150 1101	inquity occurred	
Division of Vital Records, P.O.	r Atte ter des irector	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			et, factory, office	28	f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
Ó	oital o									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 — Medical Exar	ysician: To the best of my kno niner: On the basis of examinat rse Practioner: To the best of	tion and/or investi	gation, in my opinion, dea	ath occurred at the	e time, date and	place, and due to the	cause(s) and manner stated.
	To th withir То th сотр	2	29b. Signature and title of certifier		, morriouge, u	29c. License numb			d. Date signed (Mont	
			Jahorea.	Semba Ch	ENP	R1453	510	N	wemp.	7,2009
	\		30. Name and address of person who		em 23a) (Type, Pi	a constitute of	- April -			
	\		Kelbacco St	CULO 555	URST-	Tousant	aun t	Siva -	Tausan	MO 21964
	Stat Registra		NOV 1 U 200	32. Registrar's Sign	- park					

Director

Be Completed by Funeral

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Physician /Medical Examiner

Funeral

Please Type or Print in Black Indelible Ink. Ensure	All Copies Are Legible.
State of Maryland / Department of Health and	
= For State Registrar Certificate of Death	Reg. No. 2009 35972
1. Decedent's Name (First, Middle, Last) Ann (Unningham)	2. Date of Death Month Day Year November 6, 2009 3. Time of Death 5:29 P M
4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Dea	
Greater Baltimore Medical Center Towson	Baltimore
5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Months Days Hours Mir	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MD NIA Baltimore	1 ⊅res 2 No
10e. Street and Number	10g. Citizen of What Country?
16 13 Stonewood 12d. 21239	Specify Yes or No- 14. Race - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, Pue	orto Rican, etc.) Black, White, etc.
If Yes, Give 1 □ Yes 2 ☑ Mo Specify: 3 □ Widowed 4 □ Divorced Year or Dates:	Specify: Black
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking
Elementary/Secondary (0-12) College (1-4or 5+)	v Own Home
	ame (First, Middle, Maiden Surname)
unk Ju	ne Harvey
Mr. Shawn Cunning ham 1613 Stonewood	Rural Route Number, City or Town, Slate, Zip Code) Rd. Baito, Mo 21239
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility	16/09 Woodlawn MD
Landre Gran 2222 Cl Nac	th Ane. Batton MD 21216
23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heaft failure. List only one cause on each line.	iac or respiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition Metastatic Breast Cunce	Officer and Dodge
resulting in death) a. Due to (or as a consequence of):	
Sequentially list conditions, Due to (or as a contraction of):	
fraily, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury	
that initiated events c	
d	
IF FEMALE:	
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical 26. Place of D	1 □ Yes 2 □ No 1 □ Yes 2 □ No Death (Check only one)

Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical

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Be Completed

Medical Certification: To

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

IF FEMALE: 23b. Was decede in the past 1 ☐ Yes 9 Unknov Part II. Other sig 25. Was case re-examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 ☐ DOA 27. Man ar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

20004203

Itimore Medical Center

29d. Date signed (Month, Day, Year)

P00C

7 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35973 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 31,2009 10:50A Hubert R. Dillinger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4410 Camellia Rd. Nottingham Balto 9. Birthplace (State or Foreign Country) 1 Tennessee 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** Days Hours Months **X** ∩ M 2 □ F October 29,1921 88 **Director** 413-14-4048 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination most be notified at Md. Nottingham 1 ☐ Yes 2 No Balto. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21236 4410 Camellia Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No White ģ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, it = Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless Steel 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hill Dillinger Martha ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4410 Camellia Rd. Nottingham, Md. 21236 Betty Dillinger Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-5-2009 Oaklawn Cemetery Balto. Md 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses Dik 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown cate has been si page 2 should t 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 201No certificate 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifie 30. Name and address of person who completed cause of death (Item Loms

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Wesley Roland Dodd 3:50 A.M 2009 9, November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville 13043 Beaver Dam Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace *(State or Foreign Country)* Indlana 8. Date of Birth (Month, Day, Yea 1/5/1923 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Hours Min. Months Days 1473M 2□ F 218-18-2334 Director 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Medical Examination profit of an once. Cockeysville Maryland Baltimore 1 ☐ Yes 21 No Director 10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number 21030 13043 Beaver Dam Road of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1- GYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐Yes 2☐No Specify. 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) cash register sales self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adeline Agne John Dodd ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type. Print) Mrs. Nina Dodd/ wife 13043 Beaver Dam Road Cockeysville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Menorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date p⊕Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 Donation 5 Other (Specify) 12, 2009 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral &Cremation Ctr.,P.A Moter 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DISCASE NSO /Medical Due to (or as a consequence of): **Examiner** PULMONARY DISEASE DB, MUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Por Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed ours after death.

eral Director: After this certificate I filled in by the funeral director, page 1 □Yes 2 No ¹□Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗷 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 14 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760. Division of Vital Records, death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed To the Hosp within 24 hou To the Fune completely fi

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8320

32. Registrar's Signature V ZUU Barke

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Harold Clarence Decker, Jr. 7:45 PMNovember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Year, 19 Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Director 219-32-7217 76 Germany 1933 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8774 Cimarron Circle 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Uidowed 4 N Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Advertising Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Art Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Clarence Decker, Sr. Martina Dolores Lynch NOVEMBER 5, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Willinghan/Daughter 8110 Evergreen Drive, Baltimore, MD 21234 Health 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1
Burial 2
Cremation 3
Removal from State 7109 Forest Hill, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Evan: 8800 Name and Address of Facility Vans Funeral Çhapel & Cremation Services Harford Rd. Parkville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Due to (or as a consequence of): Exami and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death HAROLD DECKER 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy perforn 2 **X** No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After tompleted filled in by the funera 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year) 2009 ess of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 7/2009

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 5 9 35976 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2009 Dino Michael Dipaola Nov. 11:15 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Forest Hill Harford County 30 C East Jarrettsville Road 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year Months Days Hours Maryland 1 XM 2 ☐ F 53 218-68-1672 May 3, **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evariant is unat be notified at 1 ☐ Yes 2√2 No Director Maryland Harford County ForestHill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21050 30 C East Jarrettsville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1∐Yes 2∭XNo Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, Il 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie J. Maggitti Salvatore M. Dipaola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Mrs. Dawn Dipaola (Wife) 30 C East Jarrettsville Road, Forest Hill, Maryland 21050 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/12/2009 Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air cer 3 Newport Drive, Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEAD AND NIECK CANCER 240425 Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed as the burial-transi and Due to (or as a consequence of) Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been a al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 213 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 1 Tes Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death (Month, Day, Year) Injury + Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

PITTLEP

31. Date filed (Month, Day, Year)

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0005847

BIELATER MD 21014

ATWOOD ROAD

PHYSECIAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIVATPUMIN, 602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2009 November 4:43A Bapubhai В. Desai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 15 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 □ F Months Days Hours Min. **Director** 218-96-7962 96 1913 India Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 10214 Shining Willow Drive 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify. 3 X Widowed 4 □ Divorced Asian-Indian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dahyabhai Kashiben Bhimbhai Desai Bhimbhai permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Javahar Bapubhai Desai/son Shining Willow Drive Rockville, Maryland20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 11/7/2009 Odenton, Maryland Sign Fre of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. R Homes tanita Odenton, Maryland 21113 Annapolis Road 23a. Part NEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death EUMONIA ₽nysician disease or condition resulting in death) N Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on burial-transi been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 🗌 No 9 Unknown 9 Unknown Ö CO. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate has autopsy completed filled in by the funeral director, 25. Was case referred to medical Be 26. Flace of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No □ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 200 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Co. 200

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nor	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 Removal from Stat	e ce	emetery, cren	natory or other plac	^(e) 11/	Date 9/09		ocation - City or To	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o once.		1. Sign for Jun 19 Sangar	Licon A A	рита			norial Ga			monium,	
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<u></u>	should nd Me mark matic	욘	19a. Informant's N		nip (Type, Print)		19b. Mai	ling Address (Stree	1			er. Citv or 1	Town. State.	Zip Code)	_
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ָרָ מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural; or items Z3a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Dis	position		20	b. Place of Disc	nosition (Name of		D	ate	20c. Loca	ation - City or	Town, State	-
	Page ment ant: If ury o		1L X Burial 2 l 4 ☐ Donation		3 □ Removal from Decify)	State	olumbiá M	ematory or other pla lemorial Gar	dens	11/10)/2009	Clarks	ville,M	aryland	
ğ	permit. Departn Importa any inju		21. Signature of F	uneral Service I			F	22. Name and Addr Teck Funera	ess of Facil Home	ity Inc.					
	<u>~</u> □ = « «		M	MA	M01234	_		601 Sandy S	pring	Road,	Laurel,		nd 2070		_
			shock, or hea	art failure. List	complications that only one cause on	e o line.	**	nter the mode of dy		_				Approximate Interval Between Onset and Death	
No.	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	_a/	etre	peri	tonea	CB	100	dras			VAUS	Þ
	Examiner				Due to	o (or as a con	sequence of):	other			9			DAY	-
		Jer	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	ndifions mediate	b. — Due to	(or as a con	sequence of):	- In		P	-1			DAYS	-
	cuted nd ransit	Examiner	Cause (Disease or that initiated events	injury	c	Dee	PVE	cia Th	CON	ulx	5515			2745	
Š	oe exe cian a urial-t		resulting in death)	Last	Due to	(or as a con	sequence of):								
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<	death certificate be executed e attending physician and d for use as the burial-transit	cian/Medical	IF FEMALE:		23c. If yes, or	utcome of pre	egnancy					22	d. Date of de	divory	
2	death atter	iciar	23b. Was deceden in the past 12 1 ☐ Yes 2	mantha?	1 Live	e birth 2 ☐ f gnant at time	Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23	Month	Day Year	
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Ś	w require been signatures										1 🗆	Yes 2	No 3□P	robably 4 Unknown	ı
	law r nas be	Completed									24a. Was auto		24b. Were a	utopsy findings available completion of cause of	
	: The cate h	Con									perfo 1 □ Yes	2 No	death?	s 2 🗆 No	
A	Attending Physician: Therefeath. ector: After this certificate by the funeral director, pag	Be	25. Was case refer examiner?		Hospital:			Ot	hor:		(Check only				_
5	Phys r this ral dii	5	1 ☐ Yes 2	at his time to		Inpatient 2 e of Injury	2 ER/Outpation 28b. Time	SIIL SLI DOA	4 U N		me 5 Resi			ecify)	_
5	th. : After : funer	ţi	1 Natural	5 Pending	a (Mo	nth, Day, Yea		Wo	rk?]Yes 2.□		-00. 20001120	non injury i	00001100		
2	Attendi r death. ector: A by the fu	ifica	3 Suicide	6 Could r	and 200. Flat	e of Injury - A	At home, farm, s	treet, factory, office		- 1	28f. Location	Street and	Number or R	tural Route Number,	
5	tal or s afte al Dir ed in	Certification:	4 ☐ Homicide		Dulie	ding, etc. '(Sp	iecity)				City or To	wn, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 Certifyin 2 Medical i	Examiner: On the	ne best of my basis of exar nner stated.	knowledge, dea nination and/or	ath occurred at the investigation, in my	time, date a opinion, de	and place, eath occurr	and due to the ed at the time	cause(s) a , date and p	and manner a place, and du	as stated. e to the cause(s)	
\	Vith:	Ž	29b. Signature and	title of certifier	(KI)				se number	7930				th, Day, Year)	
			30. Name and add	ress of person		use of death ((Item 23a) (Type	Print)	ŠH.	204-	adi	3411	uso	70832	_
	Stat Registra	-	31. Date filed (Mon	th, Day, Year) 0 2009	General 32.	Registrar's Si									
							* 6								-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 10:55 P M John Lewis Edler 4, November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days **™** 2□ F **Director** 213-36-8228 July 11, 1939 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be netitied at 1 Yes 2 No Maryland Harford Bel Air Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 East MacPhail Road 21015 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 TNo à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Vice President</u> Energy Health and Mental Hygie em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked 1 any injury or other traumatic ew once. James Alvin Edler Anna Teresa Szymanski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Clark Edler / Wife 1401 East MacPhail Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-9-09 Bel Air, Maryland Zion U.M. Cem. 22. Name and Address of Facility McComas Funeral Home, P.A. Umas 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Rarli Enterine disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequent of) nding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) TYPS 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number

10+1

State Registrar 65 W. mcPlai

32. Regetrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Junn, m.D

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 Month MBER Day Ellis EY87219 5:49A Hoyie (nmn) Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center timore OWSON If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea NOV 2 1 9. Birthplace (State or Foreign Days 1**X**M 2 □ F Months Hours Min. 88 240-20-3089 Director Carolina Nov Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Darlington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21034 USA 1557 Deerfield Road ural", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2XXNo Maryland 21215-0036 1 ☐ Yes ZXNo Specify: "natural". 3 XXWidowed 4 Divorced Specify: Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Plumber / Electrician Residential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Samuel Ellis Nora Alice Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3890 Delta Road, Airville, Pennsylvania 17302 Rita Dalton / Daughter Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nov. 12, 2009 Darlington, Maryland Darlington Cemetery ture of Funeral Service 22. Name and Address of Facility McComas funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner INTRA ABDOMINAL ABSCESSES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit PERFORATED DIVERTICULITIS that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?

1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury 1 Acus.
2 Acus.
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 11-07-00 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W OSLER DRIVE. TAT TOWSON.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

r's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2:05 AM /Medical Nav. acilly Name (If not institution, give street and number, City, Town, or Location of Death Examiner 4c. County of Death tonsu: lle Vlanor timore Social Security Number 8. Date of Birth (Month, Day, 3 - 25 Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 💢 F 239-60-1606 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Neolea Examirst must be notified at MD Completed by Funeral Director 1 Yes 2 No HMOre 10e. Street and Number 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 Is marked oth Be 9a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau Baltimore WD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Burial 2 Cremation 3 R 3 Removal from State 21. Si vay re of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVASCULAR - Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) The law requires that the death certificate be executed burial-Due to (or as a consequence of) physician at the burial Box 68760 Physician/Medical attending p for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | ed by the a 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 2 No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 No page certificate Vital 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Division of After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar BUSINESS CENTER DRIVE

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g897 11/10/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year Erans Elizabeth 22:55 November 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Sept. 1, 1930 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ XF 212-28-9420 79 Yrs. Director MD Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner Liust be notified at Director MD Baltimore 1 ☐ Yes 2 ☑ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1000 Franklin Avenue Apt. 1006 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iten any Injury or other traumatic event, the Midical Examina any Injury or other traumatic event, the Midical Examina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Kio Specify: Ś Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office MAnager Distributors 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Prion ဥ Elanore Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Kowalewski /daughter 1008 Cord Street Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial → ☐ Cremation 3 ☐ Removal from State Bayview Crematory 11/7/09 5 ☐Other (Specify) Baltimore MD 4 ☐ Donation 21. Sig place of Furery Service Leensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD MHU Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a nsequence of): /Medical Examiner Neordistria foscillis Sequentially list conditions, if any heading to min-diatocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Vear Day 5 Other (specify) 1 ☐ Yes 2 🖼 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hat the rector, p. ge 2 s autopsy performed? funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this (1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 6

State Registrar Brenessa

31. Date filed (Month, Day, Year)

John Hopkins Hospital, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lindeman

5 4

ATHERINE

DHMH 17 Rev 1/2001

State Registrar Tustine

31. Date filed (Month, Day, Year)

BALTO. MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#30perDVR, G897, 11/10/09 WS State of Maryland, Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 ear 6:30 Wallace Elmo Faulkner November /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8702 Lisa Lane Randallstown Baltimore 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea 11-5-1924 Funeral 9. Birthplace (State or Foreign Months Days Min. Hours Director 226-24-8978 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Wedical Exeminar is ust be notified at Director Mi Baltimore Randallstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8702 Lisa Lane Funeral 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√☐ No Specify: Specify: African-American 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, the Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Crane Mill worker Bethlehan Steel 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Nannie M. Murchy Daniel H. Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Waite/Daughter 8702 Lisa Lane, Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) Garrison Forest Veterans 11-18-09 Owings Mills, Maryland 22. Name and Address of Facility Wile Funeral Home PA.. of Baltimore Co. 21. Signatury of Funeral Service Licensee 9200 Liberty Road, Randallstown, Md 21133 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic disease or condition resulting in death) enknown /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Year 5 ☐ Other (specify) been signed by the should be detached 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 3 certificate ermens 1 Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) No No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of leath Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 9109 38041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thakor 1 Chisa MB 4 W. Rolling Crossroads #100 Baltimore, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State Registrar		State of I	Marylan	d / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	lealth a Death	and M		giene Reg. No.	200	9	359	986
	Physici		Decedent's Name (F	First, Middle, Las	-		F	2 1	ノス	=		2. Date of Dea Month	ith Day	Ye		3. Time of D	
	/Medic Examir		4a. Facility Name (If no	1 1/ /	street and numb	er)	1	4b. City	, Town, or	Location o	f Death	November	_	County of D		41.5	
	Funeral Director		5. Social Security Number 214-54-5860 Usual Residence of Dec	ber 6. Se			last birthday)	If Under	er 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Dat 2/20/19	h (L Year)	9.	Birthpla Counti	ace (State or ry) MD	Foreign
	Maryland a-f show	ctor	10a. State 10	ob. County Inne Arund	el		y, Town or Lo Glen Bu		-						10	d. Inside City	
	h with the 23a or 28 st be not	al Dire	10e. Street and Numbe						ip Code 1060				10g. Citiz	zen of What USA	Countr	ry?	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "McCal Evry: that," ust be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 XMarried	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? MNo		Was Dece If Yes, sp 1 □Yes		ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)	- 1	14. Race - A Black, W Specify: A	hite, et		ican
21215-0036	filed within 72 ha Hygiene. Ither than "natu	Completed	15. (Specify of Elementary/Secondal 12th	. Decedent's Edu only highest grad rry (0-12)	cation de completed) College (1-4d	or 5+)	16a. Dece (Give life. Study	kind of w DO NOT i	ork done d use retired	ation during most VLSOL	of workir	ng		nd of Busine Park Sc			
Maryland	should be file and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First Stanley Franz	æ						Ange	ela Co						
	and 2 sho ealth and n 27 is m		19a. Informant's Name. Valerie A. Fr	canze/Wif							Burni	ie, MD 21	060				
Baltimore,	. Pages 1 and 2 tment of Health a tant: If item 27 is jury or other trai		20a. Method of Disposit X□ Burial 2 □ Ci 4 □ Danation 5 □	remation 3 🗆		te Cac	Place of Dispo emetary, creming the control of the	natory or Ceme	other plac ELY	- 1	11-1		Glen	cation - City Burnie	, MD		
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funera	lan -	U Wel	lui	92	00 Lil	certy 1	Road, I	Randa]	e funeral Ustown,	MD 21				
	Physician /Medical Examiner		23a. Fart 1. Enter the d shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)	allure. List only o	ne cause on eacl a	sed the death h line.		er the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		İ	Approximate Interval Betwe Onset and De	een eath
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlyin Cause, [Uisease or night that initiated events resulting in death) Last	diate ng ry	с	as a consequas a consequ											
P.O. Box 68	The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ No 9 □ Unknown	nths?	23c. If yes, outcor 1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow	h 2□ Feta nt at time of d	Ideath 3□	☐ Ectopic ☐ Other (s	pregnancy	/			2	23d. Date of Month		y Day Ye	ar
	w requires that been signed b should be deta		Part II. Other significar	nt conditions co	ntributing to deat	n but not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to		/		cause of dea	
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	<u>a</u> + <u>a</u>	on: To	27. Manner of Death	□ Pendina	28a. Date of I		ER/Outpatier 28b. Time of Injury		28c. Injury Work	4 🗆 1901		ne 5 Resid			Specify)	<u>'</u>	
Division	To the Hospitallor Attending within 24 hours after death. To the Funeral Lirector: After completely filled in by the funeral completes the funeral completes of the funera	Certification: To	2 Accident	investigation Could not be determined	28e. Place of		ome, farm, str	М	1 🗆 '	Yes 2□N		28f. Location (S City or Tow	treet and n, State)	d Number of	Rural	Route Numbe	er,
_	ne Hospital n 24 hours ne Funeral detely filled	Medical Co	29a. Certifier (Check only one)	Certifying Phy Medical Exam	sician: To the be iner: On the basi and manner	s of examina	wledge, deatl tion and/or in	h occurre vestigatio	d at the tin	ne, date an pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manne place, and	r as sta due to f	ated. the cause(s)	
	To the vithing the comp	Me	29b. Signature and title	of certifier	Quan en a				C. License		70			e signed (M		ay, Year)	-
	51		30. Name and ordress		ompleted cause of	•	23a) (Type,	Print)			Rai	timere					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 35987 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FOIZEMAN 09 RUBY 11:00A M November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Millennium Health & Rehab Ctn. Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 0 9 - 1 5 - 21 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 424-24-6847 88 Director ALUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. International relations are coally mitting many performed to Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, I'm Medical Examinating to other traumatic event, I'm Medical Examinating to other traumatic event, I'm Medical Examinations. ¶Yes 2□No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 USA 2355 Eutaw Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc African Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: Specify: American δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Professor <u>Alabama State</u> 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Viola Nicholas Thomas Jefferson Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6343 Grey Fox Way Riverdale, GA Tommy L. Byrd - Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 11-09-09 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee MD 21217 638 N. Gilmor Street Baltimore, Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Dementer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 9 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 **N**o 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier W 1) D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HASHMI MD, 821 N. ENTAW STENTE 308 BALTINGREMD 2120 SHOAUS 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

Foreman

Ruby

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35988 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Elsie M. French 5:30 PM November 2000 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Agnes Baltimore Hospita 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Hours Min. Days 1 □ M 🗷 □ F 228-42-0888 1933 Virginia 29, Sept. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore N/A Maryland Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 25 N. Monastery Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 22∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, et 1 Never Married 2 Married Black 1 □ Yes 21 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Y and L Transportat-Elementary/Secondary (0-12) College (1-4or 5+) School Aid 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Dixon Jasper Pettigrew 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)
25 N. Monastery Avenue Baltimore, MD 21229 19a. Informant's Name/Relationship (Type. Print) Willie French/ Husband 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/09 Concord, Virginia Archer Creek Cem. 21. Signature of Euner 22. Name and Address of Facility 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Maryland a. Par .. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause inal disease or condit in resulting in death) days Acute large
Due to (or as a consequence f): Cerebrovascular is chemic brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vascular accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

French, Elsie Division of Vital Records, P.O. Box 68760,

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur Medical

death.

State Registrar

Physician

/Medical

Examiner

Funeral

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Completed

Be

Completed by Physician/Medical Examiner

Be

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Certification:

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Examinat must be notified at

permit. Page Department of Important: If any injury or once.

Physician

/Medical Examiner

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my entire in the cause of the cause o

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

nighter Wang, MD

Avenue, Baltimore.

November 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Wang

31. Date filed (Morth, Day, Year) 32. Registrar's Signature 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 897 11-16-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2009 November 4a. Facility Name (If not institution, give street and number) owler /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, 1945 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 2 🗆 F Days 102-36-5718 63 New Director Nov 3, 1946 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location shov aţ 1 Yes 2 No or 28a-f sl notified Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number Ь pe ms 23a (must be 9509 Sylvan Dell 21045 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 15 Yes 2 □ No 6/5/1968 If Yes, Give Year or Dates: 6/30/1994 14. Race - American Indian, items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify þ 3 Widowed 4 Divorced 6/30/1994 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education ed other than "natu event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney (JAG) **US Armv** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Joseph Creamer Fowler Helen Skead ည traumatic 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9509 Sylvan Dell Columbia, MD 21045 Barbara Fowler Spouse 20c. Location - City or Town. State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition Department of the function of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Point, NY **West Point Cemetery** Nov 12, 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licenses permit. Slack Funeral Home, P.A. 3871_Old_Columbia Pike Ellicott City. MD 21043 Part 1. Enter the class se, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner ntracranio Sequentially list conditions, if any loading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 🗌 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 2 No Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Certification: To Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident Director: A 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and November MO of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 600 North Wolfe St, Baltimore, MD, 21287 KWAN NG 31. Date filed (Month, Day, Year) 32. gistrar's Signature State Registrar 10

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Dav Month 7:10 A M NOVEMBER 06 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (1001) SAMARITAN HESPITAL BACTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 212-09-5691 Va Director Usual Residence of Decedent 3a or 28a-f show 10c. City, Town or Location
Rallimore 10a. State 10b. County 10d. Inside City Limits MD Be Completed by Funeral Director 1 Wes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 1204 N. Ellwood Avenue USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 □Yes 2 No Black Specify 3 Widowed 4 □ Divorced Specify: "natural" : If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) econdary (0-12) College (1-4or 5+) a borer Steel 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F ပ Innie 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Ballimore, Maryland Daughter 1204 Ellwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department c Important: If any injury of 21. Signature of Fune A Service Licen 23a. Part 1. Ents the disease, or complications that caused the death. Do not enter a mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner BACTEREMIA MRSA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) PNEUMONIA the death certificate be exec physician ar s the burial-to Due to (or as a consequence of) Box 68760. Physician/Medical the attending phones as the IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy Division of Vital 1 □Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN 20062239 NOVEMBER OG 2019 MAN NAMA OD, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN 6000

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

10

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2009 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pauline Fritz 2009 November 4:05P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8135 Silo Court Severn Anne Arundel 8. Date of Birth (Month, Day, Year) July 13,1938 5. Social Security Number If Under 1 Year_ **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Months Days 1 □ M 2 X F Hours 218-36-6717 Director Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD 1 ☐Yes 2☐No Anne Arundel Severn Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 8135 Silo Court 21144 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1
Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Ş White 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Roger S. Fritz of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Piano Tuning & Repair Vice President & CEO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Ralph G. Perry Mary Margaret Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert A. Fritz/Son 8135 Silo Court Severn Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November permit. Pages Department o Important: If any Injury or once. ± 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Garden 9, 2009 Marriottsville, MD 21. Signature of Furieral Service Lice 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ces resulting in death) /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 🗷 № 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 9d. Date signed (Month, Day, Year) +

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

parke

200

09-08630 Alice Fickus Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 35992

		1- For State Registrar		ertificate c	of Death		R	eg. No.	
Physici	an/	1. Decedent's Name (First, Middle,Last)					Date of Dea Month	Day Vear	3. Time of Death
Medical Exami	ner	Alice I			4b. City, Town, o	r Leasting of D	November	f 6, 2009 4c. County of Deat	1122 hrs
		4a. Facility Name (if not institution, give 13215 Rivervan Avenue	street and number)		Chase	or Location of D	eatri	Baltimore Cou	
Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Ye	ar If Under 2	4Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bis	thplace (State or
Director		212-28-9841	M 2 X F	79 Y	Months Da	ys Hours	MArc	h27,1930 Co	gn ountry) MD
		Usual Residence of Decedent							
' any		10a. State 10b. County	i	City, Town or Loca	ation				10d. Inside City Limits
ɗaryland 28a-f show 1 <u>at once,</u>	ъ	MD Baltimo	ore		Chase				1 Yes 2 X No
Maryl 28a-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once		13215 Riverva				220		USA	
th wit	Funeral	11. Mantal Status 1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces?	If	as Decedent of F Yes, specify Cub	lispanic Origin? an, <mark>Mexican</mark> , Pu	(Specify Yes or No lerto Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,
ter dez ', or i			1 Yes 2 X N	0 1	Yes 2 X N	lo specify:		Specify: W.	hite
urs af tural'	d by	15. Decedent's Education (Specify onl	or Dates:	i) 16a. Decede	ent's Usual Occup	ation (Give kind		16b. Kind of Business	industry
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15-003 filed withi I Hygiene. of other th		17. Father's Name (First, Middle, Last)					lame (First, Middle, I		
2121 Muld be fi Mental I marked c event,	To Be	Frank W. Koe 19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Str		ena C.	SNIDLEY nber, City or Town, State	e. Zip Code)
MD 21215-0036 1 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 11 7 is marked other than "natural", or items 23a or 28a-f she umasite event, the Medical Examiner must be notified at once		Lawrence Fick			-			-	n PA 18902
		20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of o	emetery,	Date	20c. Location - City of	·
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N mportant: If them 27 is n njury or other traumatic		1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State	oak Lav	vn Ceme	tery 1	1/11/09	Baltimo	re MD
Baltimo permit. Pag Department Important:		21. Signature of Funeral Service Licens	ee	22.	Name and Addre	ss of Facility	300 MAC	e Ave.Bal	to. MD
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		Sequentially list conditions, b	ac to (or as a consequent						
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		 Name and address of person who could be supported by the support of the		tem 23a) 11 Penn Stre	et. Baltimore	. MD 21201			
9	ate	31. Date filed (Month, Day, Year) 1	32. Registrar's Sig	- K	Just				
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			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No 2. Date of Death	<u>, 000</u>	3. Time of Death
	Physici		Lola, Gary		Month Da	Year	5: 20pm
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death		. County of Death	
d'a				Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	Ionths Davs Hours Min.	B. Date of Birth (Month, Day, Year,) Cour	place (State or Foreign
	Director		215-36-8356 Usual Residence of Decedent		September	21,1940	Maryland
	ryland how		10a. State 10b. County 10c. City, Town or Locat			1	0d. Inside City Limits
	Ra-fs	ecto	na. Bares.	arkville			1 □Yes 2 □No
	with th	Funeral Director		10f. Zip Code	10g. Ci	itizen of What Cour	ntry?
	ns 23	eral	8526 Harris Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21234 s Decedent of Hispanic Origin? (Spec	ifv Yes or No-	USA 14. Race - Americ	an Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Midcal Event instruction in any once.	by Fur	1 □ Never Married 2 1√2 Married 1 □ Yes 2 1√2 No	s Decedent of Hispanic Origin? (Spec ss, specify Cuban, Mexican, Puerto R Yes 2 ∑ No <i>Specify:</i>	ican, etc.)	Black, White,	
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	/Medical Examiner		Due to (or is a consequence of):	1 (11 (il
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, at tigation, in my opinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as s nd place, and due to	stated. o the cause(s)
	To the within To the Comp	ğ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
			John Quyl, MD PGYI	1104051283	New	mber 8th	2004
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	_	Baltimas, 1	lan 7	1701
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		MITIMAN , 1	- U &	120;
	Registr		31. Date filed (Month, Day, Year) NOV 1 0 2009 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per fn G902 4/6/10 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 35994 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 09,2009 **Physician** James J. Gabinet November 3:24 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7406 Meadow Branch Court Apt.C Rosedale Baltimore County If Under 1 Year | If Under 24 Hrs. 214-14-8820 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 121M 2□ F 89 Aug. Baltimore, MD. Director 07,1920 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If flean 27 Is marked other than "natural", or items 23a or 28a-f show any hujury or other traumatic event, it is not be any injury or other traumatic event, it is not be any injury or other traumatic event, it is not be any injury or other traumatic event, it is not be any injury or other traumatic event, it is not be any injury or other traumatic event, it is not be any injury or other traumatic event. Director 1 Yes 20 No Maryland Baltimore County Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7406 Meadow Branch Court 21237 Apt.C United States Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □ No Specify 2 W.W.II Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Moreland Memorial Elementary/Secondary (0-12) College (1-4or 5+) Berevement Counselor Park 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Gabinet Anna Sommar ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Castalian Springs, TN. 37031 Carolyn M. Bullock (Daughter) 660 E. Robertson Road 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 13, Moreland Mem.Park 4□Donation 5₺Other (Specify) Fintombinent Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funera 2325 York Road Timonium, Funeral&Cremation Ctr., P.A. phium, Maryland 21093 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrier Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical ası attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 □Yes 2 □No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident hours after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) by

32. Registrar's Signature

Year.

1 u 2009

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5-9 per fh g897 11-12-09 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 35995 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 11:04 AM GRIFFIN NOVEMBER 5 Dallas 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Galtimore Sinal Hospital
Social Security Number 6 9. Birthplace (State or Foreign Country)

N.C. 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1**⊠** M 2□ F 237-52-4701 72 11-10-1937 Director Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanina, the routified anone. 1 Yes 2 □ No Director timore mi 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 907 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 MYes 2 No If Yes, Give Year or Dates: 1257 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cubap-Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 9 ac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sel Visor 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ပ mue 19a. Informant's Name/Relationship 19b. Mailing Address (\$treet and Number or Royal Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory of other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vauchin 21. Signature of Funeral Service Licensee mo21229 to. Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORANARY ARTERY DISGASE /Medical Due to (or as a consequence of): Examiner Due to (br as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Obstructive After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 43048 -09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID BUERSMA 7505 USCER USS MOL 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-08451 State of Maryland / Department of Health and Mental Hygiene Abraham Dallas Golden, Jr. 2009 35996 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2009 1736 hrs Medical Examiner GOLDEN JR. DALLAS **ABRAHAM** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Baltimore N/A 3901 Dorchester Road Apt 3 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Foreign MARYLAND Country) Days Months Hours Min Director Yrs 07/22/1959 1 X M 2 F 215-74-9573 50 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 XXYes 2 No 28a-f show BALTIMORE 23a or 28a-f sho notified at once, permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho filer or other reaunatic event, the Median Examiner must be notified at once injury or other reaunatic event, the Median Examiner must be notified at once. N/A MARYLAND rector 10f, Zip Code 10g. Citizen of What Country 10e. Street and Number U.S.A. ﻕ DORCHESTER RD 21215 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Yes 2 X No specify: Specify: BLACK If Yes, Give Yea 4 X X Divorced 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 WOODLAWN EMT 12th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDNA E. MONTGOMERY ABRAHAM D. GOLDEN SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4135 Mountwood Rd., Baltimore, Maryland 21229 Anthony C. Golden Sr./Brother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place)

Metro Crematory

Metro Crematory Baltimore 1 XX Burial 2 Cremation 3 Removal from State 11-13-09 DUNDALK, MARYLAND 4 Donation 5 Other Specifi 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature une Service Aconsee 1206 W NORTH AVENUE 23a. Part I. Fifer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical $\overline{\mathbf{x}}$ AMENDED 20b,c per fh g897 11-10-09 vt LINPENDED attending physician for use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö δ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has b rector, page 2 sh performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26 Place of Death (Check only one the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Division of Vital Be Hospital: DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 Director: Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hours al To the Funeral I determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 1, 2009 O.C.M.E. hell 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State

Margarita Korell MD.

31. Date filed (Month, Day, Year,

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 35997 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lee Garst 2009 Nancy November 10:55P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🔀 F Hours OCT. 9 Year) 937 Mary land Yrs. Director 430-72-3297 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Frederick Frederick P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9629A Woodsboro Rd. 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 sterilization lab technician medical research traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Winfield Scott Rippeon Pearl Virginia Curfman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other trau Raymond R. Garst Sr./ husband 9629A Woodsboro Rd. Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 🔯 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/5/2009 Pleasant Hill Cem. Monrovia, MD 21. Si pre Frineral Service bi en e 22. Name and Address of Facility Hartzler Funeral Home Bren 077 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine Ponset and Death Immediate Cause (Final Embolism ulmonary aliysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Dav Year detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopathy sign be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has performed? Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 Mo မ 1 Tyes 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

W.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRILL, UD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Gettifying Prijarctain: To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7901 Maple Ave., Takoma Park, WA 20912

November 2, 2009

29c. License number D34601

09-08650 Bridget Suzette	Hub		or Print in Blace of Maryland / D				•	_egibl	e.	
		1- For State Registrar			ate of Dea			Reg. No	20	00 250
Physicia Medical Exami		1. Decedent's Name (First, Middle, La Bridget Suzett					2. Date of Month	Death Day ber 7, 2	nno Year	0238 hrs
J. W. W.		4a. Facility Name (if not institution, g			4b. City	, Town, or Location		4	c. County of De	ath
* ;		4302 Winners Circle 5. Social Security Number 6.3	Sex 7. Age (II	n yrs. last birl		camp	der 24Hrs. 8. Date o		Harford VDD/YYYY) 9.	Birthplace (State or Foreign
Funeral Director						nths Days Hou	rs Min.	20,19	1	Country) faryland
		Usual Residence of Decedent					Flay	20,19	04 [F	
ow any		10a. State 10b. County		c. City, Town		1				10d. Inside City Limits 1 Yes 2 X No
aryland 8a-f sh at onc	Director	Md. Balt 10e. Street and Number	0.	W	hite Ma	rsn Zip Code		10g. Cit	tizen of What C	
th the Maryland 23a or 28a-f show notified at once.		11152 Philadelp	hia Rd.			21162			USA	١
ath with tems 2 st be n	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Eve Armed Forces?				rigin? (Specify Yes on, Puerto Rican, etc.		14. Race - An White, etc	nerican Indian, Black, c.
fter de	by Fu	3 Widowed 4 NDivorce	1 Yes 2 X	No	1 Yes	2 X No specify	y:		Specify:	White
hours a natura Exami		15. Decedent's Education (Specify		eted) 16a.		al Occupation (Give	e kind of work done T use retired)	16b.	Kind of Busine	ss/Industry
036 ithin 72 ne. r than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Packer				Food In	dustry
215-0036 be filed within 7 ttal Hygiene. *ked other than ent, the Medica	Be Cor	17. Father's Name (First, Middle, Las Ode11 Jackson	st)	,	_		er's Name (First, Mide ine Rayno		n Surname)	
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Berline Jackson				ess (Street and Nu Philadelp	umber or Rural Route			tate, Zip Code) Md • 21162
e, M I and 2 Health item 2		20a. Method of Disposition		20b. Place		Name of cemetery,	Date			or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specia			ns of F		11-11-20	09 В	alto. M	ld.
Balti Departit Import Injury		21. Signature of Funeral Service Lice	ensee			ind Address of Facil	Schimun			
Physician	- 44	23a. Part I. Enter the disease, or con		death. Do n	1 970. ot enter the mod	5 Belair de of dying, such as	Rd. Not cardiac or respirator	tingh y arrest, sh	am. Md. nock, or heart	Approximate Interval
/Medical xaminer	1		each line. _{a.} Intraoral Gunshot	Wound of	Head					Between Onset and Death
1		or condition resulting in death)	Due to (or as a consequent).	ence of):						
	Examiner	if any, leading to immediate	Due to (or as a consequ	ence of):						
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oe exectician an	sician/Medical	UNPENDED	AMENDED					-		
68760, certificate be ading physic	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		2 Fetal dea	ath 3 Ector	oic pregnancy	23	3d. Date of deli	very Day Year
Box 68760, re death certificate be executing the attending physician and red for use as the burial - trai	/sicia	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at tim		5 Other (S			- 1		
ires that the cost signed by the detached	by Phy	Part II. Other significant conditions	s contributing to death be	ut not resultin	ng in the underly	ring cause given in I	-			e to the cause of death?
rds, P requires t been sign hould be of					-			∫Yes 2∦ Wasan	✓ No 3 F	Probably 4 Unknown a autopsy findings available
of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should t	Completed							autopsy performed?	prior	to completion of cause of
tal Rection: The certificate	Be Co	25. Was case referred to medical					h (Check only one)	63 2		103
F Vita Physici ar this o	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient		outpatient 3	DOA Other	Nursing Home			ther: Scene Friend
on of value Ph. ath.		27. Manner of Death 1 Natural 5 Pending		000	Time of Injury O hrs	28c. Injury at Wo	 Subject 		njury occurred f	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Certification:	2 Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Injury		arm, street, fact	ory, office building,	or To	wn, State)		Rural Route Number, City
Die Hospital		4 Homicide determing 29a. Certifier 1 Certifying Phys	ician: To the best of my ki		eath occurred at	the time, date and p	1		le, Belcamp, and manner as	
To the I within 2 To the I complet	Medical	one) 2 Medical Examin	ner:On the basis of examin and manner stated.		investigation, in	my opinion, death	occurred at the time,	date and p	lace, and due t	o the cause(s)
	ا≥ا	29b. Signature and title of certifier			- 1	29c. License numbe	31	29d	. Date signed ((Month, Day, Year)

8

State Registrar DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2009 32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Ian Howard November 2009 \mathbf{P}_{M} 1:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours (Month, Day, 23 215-27-7039 Director Mary 1 and Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Parkville or 28a-f 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 3006 Dubois Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2X No Specify: "natural", Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coddard NASA Space Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Flight Center Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Wayne Howard Cheryl Lynn Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl L. Howard 3006 Dubois Avenue, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/12/09 Parkville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility. Evans Funeral Chapel & Chemation Services 8800 Harford Rd., Parkville, MD 21234 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to influed ate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month 4 Pregnant a 9 Unknown Records, P.O. by signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l , page 2 s autopsy perforn death? certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pendina 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cer 64395 NOVEMBER 7,2009

State Registrar 6701 NCHARLES ST, SUITE 4105 BALTIMORES US 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

DANIEUE DOBERMAN,

U 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 36000 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOV. Michael Joseph Hartnett, Jr. 200gr 9:11 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 30 Valley Bottom Road Aberdeen Harford County 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 214-16-9433 89 Director July 9, 1920 Maryland Usual Residence of Decedent 10a. State show 10h. County 10c City Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at Director Maryland Harford Co. Aberdeen 1 ∐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Valley Bottom Road 21001 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Steel Worker i 2 should be filed w h and Mental Hygiel 7 is marked other tt Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Hartnett, Sr. Ethel Sternsdorf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traur Mrs. Lucille Hartnett (Wife) 30 Valley Bottom Road, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel | 11/07 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
Evans Funeral Chapel & Cremation Services — BelAi 21. Signature of Funeral Service Licensee fouts of 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a END STAGE RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HYPERTENSION DIABETES MELLITUS 1 ☐ Yes 2 📆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar

622

within 2.

29c. License number

SIUNION AVE

, HAVRE DEGRACE, MD 21078